IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, vs. CITY OF CLEVELAND Defendant.	)	CASE NO.: 1:15-CV-01046 JUDGE SOLOMON OLIVER, JR. **MOTION REGARDING ALL-OFFICER, EIGHT-HOUR CRISIS INTERVENTION TRAINING**

Pursuant to Paragraph 143 of the Consent Decree and the Second-Year Monitoring Plan, the City of Cleveland (the "City") has submitted to the Monitoring Team a curriculum for providing training in responding to individuals experiencing a behavioral crisis – including mental health, substance abuse, and other behavioral health challenges – to all Cleveland Division of Police ("CDP" or the "Division") officers. The curriculum contains four courses or units to be taught over eight hours (collectively, the "Eight-Hour Curriculum"). These courses cover the new CDP Crisis Intervention Policy, attached hereto as Exhibits A through F; an Orientation to Mental Illness, attached hereto as Exhibits G through I; an introduction to Communication and Active Listening, attached hereto as Exhibits J through L; and an explanation of the Command and Control Paradox, attached hereto as Exhibits M through O. For each course, the attached documents include a PowerPoint presentation file that will be used

in the training, a lesson plan covering the specific curriculum, and an instructor's manual that provides training personnel with additional information.

The Monitor has previously updated the Court on the City's establishment of a Mental Health Response Advisory Committee (the "Advisory Committee") pursuant to Paragraphs 132 through 134 of the Consent Decree. Dkt. 97 at 7. The City partnered with the Alcohol, Drug Addiction and Mental Health Service Board of Cuyahoga County ("ADAMHS Board") to develop this Advisory Committee. *Id.* at 37. The Advisory Committee consists of members of the community; including mental health professionals, advocates, individuals recovering from mental illness and addiction disorders, Cleveland's Municipal Court, the State of Ohio Criminal Justice Coordinating Center of Excellence ("CJCCOE") as well as representatives from the City and CDP. *Id.* Representatives from the U.S. Department of Justice ("DOJ") and the Monitoring Team also participate in the Advisory Committee's meetings. The Advisory Committee continues to meet regularly and has worked hard to "foster relationships and build support between the police, the community and mental health providers." Dkt. 7-1 ¶ 132.

The Advisory Committee appointed a Training Subcommittee to work with CDP and the City to develop a set of curricula that met the Decree's requirements that all CDP "officers . . . be provided with at least eight hours of initial training . . . adequate in quality, quantity, type, and scope" addressing, among other things, "how situations involving individuals in crisis should be addressed . . . . " *Id.* ¶ 143. The development of the curriculum to satisfy this initial training obligation took many months of hard work. This Eight-Hour Curriculum is the first curriculum developed by the Training Subcommittee. The Training Subcommittee and CDP obtained significant community input from individuals recovering from mental illness, advocates, local, state, and national experts. The Department of Justice and Monitoring Team provided technical

assistance throughout the process. The Advisory Committee as a whole ultimately approved the curriculum now submitted to the Court.

The Monitoring Team has closely reviewed the final Eight-Hour Curriculum. It concludes that the Curriculum reflects an exceptionally high-quality curriculum that follows best practice strategies concerning effective adult learning. The curriculum covers an impressive but reasonable quantity of material within the eight hours provided. It focuses on the type of training that will strengthen the officers' capacity to respond to individuals experiencing a behavioral crisis and provides enough scope to build a good foundation for future annual in-service training. *Id.* ¶ 143. More specifically, the training addresses the circumstances in which a specialized CIT officer should be dispatched or consulted and addresses how situations involving individuals in crisis should be addressed if a specialized CIT officer is not immediately available. *Id.* ¶ 143.

Indeed, the training that the Division, Advisory Committee, and representatives of the Cleveland community have collaboratively developed represents some of the strongest and best training on basic crisis intervention issues that the Monitoring Team's experts have seen across the country. The Monitor commends the extraordinary progress and high-quality work product that the Advisory Committee has generated to date. Since the City has submitted a training curriculum that has met both the requirements and intent of the Consent Decree, the Monitoring Team recommends approval of the Curriculum.

I. SUMMARY OF CONSENT DECREE REQUIREMENTS REGARDING CRISIS INTERVENTION RESPONSE AND PROCEDURAL HISTORY

The DOJ 2014 investigation concluded that officers use excessive force against individuals who are in mental health crisis – in part because the Division's "crisis intervention policies and practices are underdeveloped." U.S DEP'T OF JUSTICE, CIVIL RIGHTS DIV. & U.S. ATT'Y OFFICE NOR. DIST. OF OHIO, FINDINGS LETTER ON INVESTIGATION OF THE CLEVELAND

DIVISION OF POLICE (Dec. 4, 2014) [hereinafter 2014 FINDINGS LETTER] at 4, 52. Consequently, the Consent Decree includes a series of requirements aimed at building upon and improving the Division's crisis intervention programs. As the Monitoring Team has previously described, the first, important step to updating Cleveland's approach to addressing individuals experiencing behavioral crisis involved the establishment of a Mental Health Advisory Committee as a forum for effective problem-solving regarding the interaction between the criminal justice system and the mental health care system as well as creating a context for sustainable change. Dkt. 97 at 37–38; *see* Dkt. 7-1 ¶¶ 131–59 (describing structure and duties of the Advisory Committee).

Subsequently, the Consent Decree required that CDP, in partnership with the Advisory Committee, revise its crisis intervention policies. *Id.* ¶¶ 153–57. New crisis intervention policies, created by the Division in partnership with the Advisory Committee and broader Cleveland community, were submitted to the Court in January 2017, Dkt. 103, and approved by the Court. Dkt. 115.

The Consent Decree requires that the Division "provide training on responding to individuals in crisis to all of its officers . . . . " Dkt. 7-1 ¶ 143. Specifically, the Consent Decree indicates that "officers will be provided with at least eight hours of initial training," and that "the initial and annual training will be adequate in quality, quantity, type, and scope, and will include the circumstances in which a specialized CIT officer should be dispatched or consulted and how situations involving individuals in crisis should be addressed if a specialized CIT officer is not immediately available." *Id.*

The Advisory Committee formed a Training Subcommittee to develop the curriculum necessary to meet the training requirements set forth in the Consent Decree. Much like the Advisory Committee, the Training Subcommittee had representatives from CDP, the ADAMHS

Board, advocates, individuals in recovery, mental health and substance abuse professionals, administrators, and the Department of Justice and the Monitoring Team.

The Advisory Committee engaged in an intense process of community input and needs assessment which included public comment on CDP training needs. In addition to the 2014 Findings Letter and the Consent Decree, the Subcommittee was also guided by two reviews of the CDP Crisis Intervention program and curriculum developed by the State of Ohio. The first review was from the ADAMHS Task Force to address recommendations for the Consent Decree. MENTAL HEALTH TASK FORCE RECOMMENDATIONS FOR THE CONSENT DECREE BETWEEN THE U.S. DEPARTMENT OF JUSTICE AND THE CITY OF CLEVELAND DIVISION OF POLICE, ADAMHS BOARD OF CUYAHOGA COUNTY MENTAL HEALTH TASK FORCE 1-5 (Mar. 2015). The ADAMHS Task Force recommendations suggested that an initial training for all officers should include a basic introduction to mental health. The report further recommended that after an initial mental health training, all officers should know how to diffuse or de-escalate a situation when dealing with individuals with mental illness. The building block of such de-escalation training was viewed as one that addressed communication and the importance of tone, compassion and respect. The second review was the CJCCOE CIT Peer Review. CDP CIT Peer Review, WOODY M, FUTO J, AND LILLEY P, CRIMINAL JUSTICE COORDINATING CENTER OF EXCELLENCE 1-13 (Apr. 2015). The CJCCOE report supported many of the recommendations of the ADAMHS Task Force but also suggested the CDP training include coverage of the responsibilities and capacities of CIT officers as well as providing more interactive learning opportunities.

Since the implementation of the Consent, the Ohio Peace Officer Training Commission issued a new Crisis Intervention training curriculum for Ohio Peace Officers. These new requirements include a series of courses on mental health and de-escalation. Peace Officer Basic

Training Crisis Intervention, Ohio Peace Officer Training Commission: Education & Policy Section 1-156 (Jan. 2016). Additionally, the Ohio Attorney General's "Interacting with and De-escalating the Special Needs Population" curriculum provided the Training Subcommittee guidance for the development of the CDP 8-Hour Curriculum.

The Training Subcommittee decided that a focus on the quality of instruction and the ability of the training to have a meaningful impact on the officer was more valuable than covering a large quantity of topics – in part because the initial, Eight-hour part of a five-year plan of providing annual training to officers that will cover important, specialized topics.

The Subcommittee also determined that the 8-Hour Curriculum to be one that would use current methods of conflict resolution. The training set a goal of teaching officers, whether for the first time or as a refresher, to connect with an individual that is experiencing a mental health crisis and show ways that the officer can direct them to the most efficient method of resolving this conflict. The CDP trainer would be paired during the training with a mental health professional, chosen by the ADAMHS Board, to ensure that the training benefits from both practical and clinical expertise. This strategy of including both law enforcement and healthcare professions in the teaching process is a highly commendable, collaborative approach.

The final draft of the Eight-Hour Training represents a product that has been through several stages of in-depth development. The initial product of the Training Subcommittee was an outline of topics for the CDP Eight Hour Training. That outline went through extensive review and feedback, which ultimately led to a more limited but realistic set of topics for the first eight hours of training. The feedback on the outline led to the first draft, which was also the subject of extensive review and feedback from a broad array of stakeholders. The final draft of

the Eight-Hour training was reviewed and approved by both the Training Subcommittee and the Advisory Committee as a whole.

Thus, the process that the City and Division have used to address the Consent Decree's crisis intervention training requirements to date demonstrates that CDP and the MHRAC Advisory Committee are continuing to work cooperatively to meet the terms of the consent decree in creating reform in CDP's program of response to individuals in crisis. This is further evidence that CDP and the MHRAC have created a dynamic forum for community input and problem solving, developed a new crisis intervention policy, and are now addressing the crisis intervention training needs of the department.

II. STANDARD OF REVIEW

The Monitor's general role is to "assess and report whether the requirements" of the Consent Decree "have been implemented." Dkt. 7-1 ¶ 351; *accord id.* ¶ 352 (requiring the Monitor to "review . . . policies, procedures, practices, training curricula, and programs developed and implemented under" the Decree). The specific task of the Monitor here is to determine if the CDP Crisis Intervention 8-Hour Training submitted to the Monitor complies with the Consent Decree's requirements. The procedural history outlined in the previous section demonstrates that CDP and the MHRAC Advisory Committee are continuing to work cooperatively to meet the terms of the consent decree in creating reform in CDP's program of response to individuals in crisis. CDP and the MHRAC have created a forum for community input and problem solving, developed a new crisis intervention policy, and are now addressing the crisis intervention training needs of the department.

The Monitoring Team, the Department of Justice, and the Advisory Committee has a number of Crisis Intervention Team ("CIT") experts who are active participants in the Training

Subcommittee. Many of these experts have worked on the national level implementing successful CIT programs. These same experts have been responsible for developing and evaluating crisis intervention curricula for programs in the state of Ohio and other areas throughout the nation, including municipalities involved in the consent decree process.

The Crisis Intervention Team model itself is now in over 3,000 municipalities nationwide, which allows for the Monitoring Team to gauge the Division's training in light of similar training initiatives implemented elsewhere. The Training Subcommittee studied a wide range of state and national curricula in developing the CDP 8-Hour Crisis Intervention Training for all officers. Specifically, The Training Subcommittee examined a series of nationally available curricula at the University of Memphis CIT Center website that was developed for the Department of Justice Bureau of Justice Assistance national curriculum study, the recently-developed Ohio Peace Officer Basic Training Crisis Intervention training program, and the Ohio Attorney General's "Interacting with and De-escalating the Special Needs Population" curriculum.

The Monitoring Team also reviews the Eight-Hour Curriculum, like all training curricula under the Consent Decree, in light of current best practices in adult education and adult learning. For instance, the Team considers whether the training is sufficiently trainee-centered, emphasizes different learning styles (visual, auditory, and the like), and uses interactive techniques to develop practical skills. *See, e.g.*, J.R. Oliva and M.T. Compton, *What Do Police Officers Value in the Classroom? A Qualitative Study of the Classroom Social Environment in Law Enforcement Education*, 33 POLICING: AN INTERNATIONAL JOURNAL OF POLICE STRATEGIES & MANAGEMENT 321–38 (2010). Studies that have focused on the complete CIT crisis intervention curriculum have found that officers are more confident of their de-

escalation skills as a result of CIT Training and demonstrate a positive change towards individuals with mental illness. *See* R. Borum, et al, *Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness*, 16 BEHAVIORAL SCIENCE AND THE LAW 393–405 (1998); M.T. Compton, et al, *Crisis Intervention Team Training: Changes in Knowledge, Attitudes, and Stigma Related to Schizophrenia*, 57 PSYCHIATRIC SERVICES 57 1199–1201 (2006).

III. GENERAL ANALYSIS OF THE CDP 8-HOUR TRAINING CURRICULUM TO TRAIN ALL OFFICERS

The Eight-Hour Curriculum to train all officers on crisis intervention meets the requirements of the Consent Decree. The Policy course or module, Exhibits A through F, of the Curriculum covers an in-depth overview of the policy for all officers. As required by the Consent Decree, the course does a good job of including the circumstances in which a specialized CIT officer should be dispatched or consulted. The course also covers a range of new policy directives, which include the role of EMS in the crisis event and crisis resources available to the officer on the scene. The Policy course is divided into two parts. The first part covers the crisis program and the second part covers the officers' response to a crisis event. The course makes use of video presentations, CDP event-based examples and meaningful question and answer sessions. The Policy course and each of the three courses include an evaluation component as part of the lesson plan. The evaluations component will assess the officers' learning as well as their view of the instructors and the training. The questions and assessment format of the evaluation are in development and will be incorporated into the schedule.

The Orientation to Mental Illness course, Exhibits G through I, covers psychiatric disorders most commonly characterized as Severe and Persistent Mental Illness ("SPMI"). Crisis events encountered by the police will most likely involve individuals struggling with

SPMI-related disorders. SPMI disorders include schizophrenia, bipolar disorder and major depressive disorder. In addition to the SPMI disorders, issues such as trauma-related conditions and certain key personality disorders are discussed. Other key issues, such as addiction disorders and a focus on detailed Veterans' issues, will be addressed in the lectures, with additional in-depth information provided to the officers. The course makes use of a number of video presentations and leaves adequate time for discussion and questions and answers. Local mental health professionals will co-teach the course and will be available to provide detailed responses to issues and concerns.

The introduction to Communication and Active Listening, Exhibits J through L, is responsive to the recommendations of both the ADAMHS Task Force and the CJCCOE CIT Peer Review. Officers will be provided with basic skills in communication and the building blocks of de-escalation strategies, with a sensitivity to concerns about safety for both the individual in crisis and the officer responding to the call for assistance. Communication and Active Listening include an initial introduction to case law governing law enforcement interaction with individuals with mental illness or diminished capacity. The course then moves to the building blocks of rapport through the use of active listening skills. As with the Orientation to Mental Illness, mental health professionals will be available to provide additional expertise in the active listening process.

The Command and Control Paradox, Exhibits M through O, course directly addresses issues in basic training in order to provide a context for the officer when learning de-escalation and communication skills. This is a practical course where officers will have time to address their own concerns about the challenges of using de-escalation skills. The course will include a video for class critique and make use of scenario-based learning opportunities. While the

primary instructors will be law enforcement trainers, mental health professionals will again be present to assist with the critique and feedback.

The emphasis on the Eight-Hour Training curriculum development was clearly on quality. The number of topics was deliberately limited, and time was allocated for the use of adult learning strategies to maximize the quality of the officer learning environment. The quantity was adequate in light of the time allotted. Additional topics will be covered in-depth in subsequent years of training. The Monitoring Team and all parties will continue to provide technical assistance to CDP and the Advisory Committee, review the Eight-Hour curriculum, and assess the success of the classes throughout the training process.

The type and scope of training provided by the Eight-Hour curriculum is consistent with the Consent Decree, the new Crisis Intervention training curriculum for Ohio Peace Officers, recommendations from the ADAMHS Task Force, and the CJCCOE CIT Peer Review study. The type of training is appropriate for adult learners with an emphasis on the practical application of knowledge, visual learning, scenario-based examples, and adequate time for participation as well as question and answers. The scope of training is appropriately focused on the new CDP crisis intervention policy, a basic introduction to mental illness, case law governing behavioral crisis events, basic rapport building, communication and active listening, and practical application of de-escalation techniques.

IV. CONCLUSION

The task of the Monitoring Team was to consider whether the City's submitted Eight-Hour Training on crisis intervention for all officers satisfies the terms of the Consent Decree. The Monitoring Team concludes not only that it does but that the training is among the highest quality trainings that it has seen on basic crisis intervention skills – reflecting the Consent

Decree, the community recommendations, the new Crisis Intervention training curriculum for Ohio Peace Officers, the recommendations from the ADAMHS Task Force report, the CJCCOE CIT Peer Review study, the Ohio Attorney General's "Interacting with and De-escalating the Special Needs Population" curriculum, and insights from a vast array of crisis intervention training initiatives from other cities.

In particular, the range of community participation in the Training committee process was impressive, with the Division joining forces with Cleveland advocates, individuals recovering from mental illness, local mental health and substance abuse professionals, the State of Ohio CJCCOE, and the Department of Justice. Consequently, not only is the substance of the Curriculum of high quality but the final Eight-Hour Curriculum represents a true community effort.

Because CDP, in partnership with the Advisory Committee and its Training Subcommittee has produced an outstanding curriculum that should have a meaningful impact on the Cleveland community, the Monitoring Team approves the Eight-Hour Curriculum on crisis intervention for all CDP officers and requests that the Court order it effective.

Respectfully submitted,

/s/ Matthew Barge

MATTHEW BARGE

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CERTIFICATE OF SERVICE

I hereby certify that on May 22, 2017, I served the foregoing document entitled Motion Regarding All-Officer, Eight-Hour Crisis Intervention Training via the court's ECF system to all counsel of record.

/s/ Matthew Barge
MATTHEW BARGE

Exhibit A

CRISIS INTERVENTION TEAM PROGRAM

Cleveland Division of Police

G.P.O. #

PURPOSE

- To increase the effectiveness of Cleveland Division of Police's Crisis Intervention Team Program

Crisis Intervention Team Program

- The CIT Program is CDP's collaborative, coordinated, plan of action that includes partnerships between CPD, the community, behavioral health and social services agencies, and advocates to provide a transparent process for positive, sustainable change in responding to individuals in crisis.
- GOALS:
- 1. Assist individuals in crisis
- 2. Improve the safety of officers, individuals and others.
- 3. Develop foundations to promote community solutions
- 4. Diversion.

CIT Coordinator

- Coordinates communication between CDP and behavioral health community.
- Point of contact for CIT related issues, including dispatching, reporting, selection, recognition , and implementation..

CIT Plan

- Staffing Plan that ensures that a Specialized CIT Officer will be available to respond to all crisis incidents.
- Includes identification and recruitment of Specialized CIT Officers.

MHRAC = Mental Health Response and Advisory Committee

- Collaborative Partner with the CDP
- Members from the Behavioral Health Community.
- Formed to build relationship between CDP and Health Providers, and to improve the CIT Program.
- Advises and assists on CDP Policies, procedures and training

Specialized CIT Officers

- Voluntary Basic Patrol Officers
- Have primary responsibility for handling a crisis incident – unless a supervisor has already assumed responsibility.
- Be open to Diversion possibilities.
- Communicate with CIT Coordinator and foster relationships with M.H. Agencies.

Specialized CIT Officers Application and Assessment

- Written Application with Supervisor Recommendations
- In-Person Interview
- Review of past Crisis Intervention Reports
- Review of Awards, Commendations, Complaints and Discipline

CIT Training

- Recruits will receive 16 hour OPOTA minimum.
- ALL Officers will receive 8 hours annually.
- Specialized CIT Officers will receive minimum 40 hours of enhanced CIT training in specific categories.

Exhibit B

Cleveland Division of Police
Lesson Plan

Title of Lesson: Crisis Intervention Team Program GPO Review

Assigned Course Number: TBD

Author: Captain James Purcell #6568

Date Written: 01/02/17

Approving Authority: PENDING

Overview:

The CIT Program GPO Review is a one-hour long presentation which will be contained in the eight-hour program: "Responding to Crises". The CIT Program GPO Review will contain the following major elements:

1. Understanding the Crisis Intervention Team Program. What the Program is, the goals of the Program, and the process for reaching those goals.
2. Understand the roles and responsibilities of the CIT Coordinator.
3. Identify the goal of the CIT Plan and mechanisms for reaching that goal.
4. Understand what the Mental Health Response Advisory Committee is, the goals of the MHRAC, and how it will accomplish these goals.
5. Identify what Specialized Crisis Intervention Team Officers are, what their responsibilities are, and the application/assessment process for becoming a Specialized CIT Officer.
6. Identify the training received by the specialized CIT officers, the training received by non-specialized CIT officers, and the training received by recruits.

Course Goal(s):

The goal of the Crisis Intervention Team Program GPO Review is to provide students with the understanding of the CIT Program, the elements that make up the Program, the goals of the Program, the mechanisms by which those goals will reached, and their role in the Program.

Course Objective(s):

Upon completion of the Crisis Intervention Team Program GPO Review participants will be able to demonstrate knowledge of the following:

1. What the CIT Program is and the Program's main objectives
2. What the main responsibility of the CIT Coordinator is.
3. What the goal of the CIT Plan is.
4. What MHRAC stands for and what the 2 goals of the MHRAC are.
5. What Specialized CIT officers do, what the standards for becoming one are, and the application process

Cleveland Division of Police
Lesson Plan

6. What training does the Specialized CIT officer receive and how much annual training for all officers?

Methodology:

Participants will be taught by a law enforcement officer . A powerpoint presentation and a handout of the GPO will serve as an instructional aids points. The instructors will also use class discussion to increase participant interest and involvement.

Target Audience:

All members of the Cleveland Division of Police

Class Size:

TBD

Evaluation Process:

Participants will complete a post-test which will examine acquisition of key points. Participants will be required to answer at at least 70% correct.

Logistical Information:

Site: Cleveland Police Academy

Training Equipment:

Computer, projector screen and speakers
Powerpoint presentation (electronic)
2 GPOs CIT Program/Definitions (handouts)
Post-test (handout)

Staffing Requirements:

Instructors: One Law Enforcement Officer

Training Summary:

All assigned participants will arrive at the designated time and go to the designated facility. Participants will receive an overview of the training, performance and learning objectives, and an introduction to the material.

Training Schedule:

0030-0000	Instructors on site
0000-0005	Introduction to the Crisis Intervention Team Program GPO

Cleveland Division of Police
Lesson Plan

0005-0010	Class discussion on their current beliefs and understanding of CIT in CDP
0010-0020	The CIT Program, goals and process described.
0020-0025	The CIT Coordinator, role and duties described, with examples.
0025-0035	The CIT Plan, goal and mechanisms described
0035-0045	The Mental Health Response Advisory Committee discussed, including what the function and makeup of the Committee.
0045-0055	Specialized CIT Officers; Role, training and selection process described.
0055-0100	CIT Training; Specialized CIT officers, other officers, recruit training broken down
0100	End of Session

Exhibit C

Cleveland Division of Police
CIT Program GPO
Instructor's Manual

Slide 1 – Title

Slide 2 – Our purpose

- Start by asking the group to explain what they know about this training. What are they expecting? What have they heard?
- How will we increase the effectiveness of the CIT Program?

Key points to make

- Communication between CDP and the behavioral health community should be on an individual basis and a departmental basis – through the CIT Coordinator.

- Effective solutions for assisting those in crisis includes better CIT response, better training for officers, better interactions with mental health community, and greater resources available to CDP.

Slide 3 – What the Crisis Intervention Team Program?

- What do you know about CIT?
- How is the current state of the relationship between CDP and mental health/social service agencies that we deal with?

Key points:

- CIT Program is a Plan of Action.
- Collaborative means we partner with mental health agencies, social service agencies.
- The Goals of the Program are assistance and safety in the short term, community solutions and diversion in the long term.

Slide 4 – CIT Coordinator

- Provides a bridge between CDP and behavioral health
- Discuss things the CIT Coordinator does, and things he should be contacted for including: Training issues, Specialized CIT Officer selection, issues involving mental health providers, and solutions for high-volume users/individuals who need a higher level of care than they are getting.

Slide 5 –CIT Plan

- Staffing Plan that provides for 25% to 30% of basic patrol officers be Specialized CIT Officers (different than current CIT officers) and identification and recruitment of enough officers to fulfill the plan. Plan does not focus on any officers besides patrol officers responding to CCS.

Slide 6 – MHRAC

- A Committee that includes members of CDP, Judges, Head of County DD, NAMI, Frontline (Mobile Crisis), Probation, ADAMHS Board, and others. MHRAC is an advisory committee, but also provides a means by which officers, through the CIT

Coordinator, can address issues that may arise in officers' contacts with behavioral health providers.

Slide 7 –Specialized CIT Officers

- *Voluntary* Basic Patrol Officers. Emphasis on voluntary
- Specialized CIT Training will provide many officers an opportunity to enhance their skills in their interactions with people in crisis.
- Diversion is moving the individual from the criminal justice system to the mental health care system.

Slide 8 – SCIT Officers Application and Assessment

- Process more stringent than in past, but similar to request for a new assignment.
- Officers will be chosen from Basic Patrol.
- Must have minimum 3 years experience.
- Must have recommendation of Supervisor and District Commander
- Assessment will include personnel file review and interview.
- Will receive 40 Hour enhanced CIT Training
- Should be capable of a more sophisticated approach to individuals in crisis.

Slide 9 – CIT Training

- All Officers will receive 8 Hours annually.
- The 8 hours will begin with a range of issues including policy, verbal techniques, and mental health diagnoses.
- Over a number of years, the training will break down into more advanced concepts, dealing with special-needs populations, Juveniles, autism/DD, Alzheimer/dementia and other issues.

Exhibit D

CRISIS INTERVENTION TEAM RESPONSE

Cleveland Division of Police G.P.O. #

Purpose

- Guidelines for CDP members to interact with individuals suffering from a crisis by

- Improving Safety
- Promoting Community Solutions
- Diversion from Criminal Justice System–

C.C.S. Responsibilities

- Shall, when available, dispatch a CIT Specialized Officer to all crisis incidents
- If none available, dispatch call to first available Two Man Car, and Specialized CIT Officer dispatched as soon as possible, from a lower-priority call, or even from another District, if necessary.

Crisis Incident Response All Officers

Responding to a Crisis Incident Officers shall:

- Assess safety risks
- Ensure Specialized CIT Officer is on scene, or request.
- Request EMS, if necessary (Medical/Violent)
- Remember, individual may be non-compliant due to a variety of factors - Can they process what you are saying?
- Information-gathering – Family or Friend?
- De-escalate where possible

Specialized CIT Officer Response

- Make individual aware you are a CIT Officer – Wear Pin/Introduce yourself
- Take primary responsibility for scene
- De-escalate
- Inform individual of next steps
- Give referrals if possible
- Diversion – consider health care system vs criminal justice

Juvenile Response

- Age-Appropriate response including language
- Contact Child Response Team CRT of Mobile Crisis – to find most appropriate level of care -not all psych facilities are appropriate for juveniles

De-escalation

- Differs from Use-of Force De-escalation
- Tactical vs Verbal

Use of Force

- Only Force that is necessary/proportional/objectively reasonable
- NOT to be used for expediency
- Be aware of positional asphyxiation

Handcuffing

- Officers may (not shall) use handcuffs on individuals solely in custody for Psych. Evaluation.
- Consider totality of circumstances
- Explain use of handcuffs to the individual and parent family members

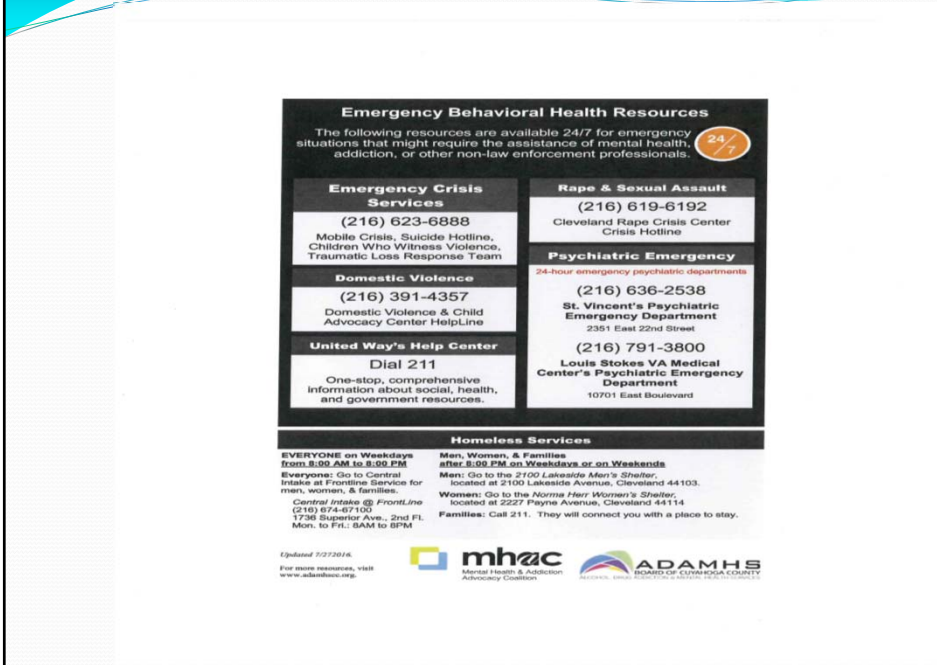
Diversion and Transport Options

- Once scene/individual is secure ask 2 questions:

1. Is there a legal obligation to arrest, or is diversion an option?
2. Does the individual need hospitalization or referral to mental health/social service agency? - Use resource cards, Mobile Crisis as resources for referral options.

Response: Non-Violent Individual able to seek care on their own

- Provide individual/family remember with name/#/address of a referral agency
- Notify referral agency of the referral
- Complete Crisis Intervention Report/CIT Stat Sheet



Emergency Behavioral Health Resources

The following resources are available 24/7 for emergency situations that might require the assistance of mental health, addiction, or other non-law enforcement professionals.

Emergency Crisis Services
(216) 623-6888
Mobile Crisis, Suicide Hotline, Children Who Witness Violence, Traumatic Loss Response Team

Domestic Violence
(216) 391-4357
Domestic Violence & Child Advocacy Center HelpLine

United Way's Help Center
Dial 211
One-stop, comprehensive information about social, health, and government resources.

Rape & Sexual Assault
(216) 619-6192
Cleveland Rape Crisis Center Crisis Hotline

Psychiatric Emergency
24-hour emergency psychiatric departments
(216) 636-2538
St. Vincent's Psychiatric Emergency Department
2351 East 22nd Street
(216) 791-3800
Louis Stokes VA Medical Center's Psychiatric Emergency Department
10701 East Boulevard

Homeless Services

EVERYONE on Weekdays from 8:00 AM to 8:00 PM
Everyone: Go to Central Intake at Frontline Service for men, women, & families.
Central Intake @ FrontLine
(216) 674-67100
1736 Superior Ave., 2nd Fl.
Mon. to Fri.: 8AM to 8PM

Men, Women, & Families after 8:00 PM on Weekdays or on Weekends
Men: Go to the *2100 Lakeside Men's Shelter*, located at 2100 Lakeside Avenue, Cleveland 44103.
Women: Go to the *Norma Herr Women's Shelter*, located at 2227 Payne Avenue, Cleveland 44114
Families: Call 211. They will connect you with a place to stay.

Updated 7/27/2016.
For more resources, visit www.adamhscc.org.

mhac Mental Health & Addiction Advocacy Coalition
ADAMHS BOARD OF CUYAHOGA COUNTY

Response: Non-Violent Individual who needs immediate care

- Determine Options for emergency care and transport or arrange transport in a safe manner to the appropriate facility – Options can be EMS, ZC, Family Member, etc.
- Complete Crisis Intervention Report/CIT Stat Sheet

Response: Possibly Violent Individual Non Voluntary

- Determine options for emergency care and arrange safe transport to facility
- If the individual is violent, call EMS to transport
- Complete Crisis Intervention Report/CIT Stat Sheet

Transporting Violent Individuals

- CDP Officers are responsible for securing the individual to the EMS cot with the supervision/assistance of EMS (**VIDEO**)
- When individual is secured, a CDP officer (Specialized CIT preferred)shall ride in the back of the EMS Unit to the hospital, with the other officer following in the ZC
- If arrested, individual shall be handcuffed and conveyed by ZC to CPU after treatment

Supervisor Responsibilities

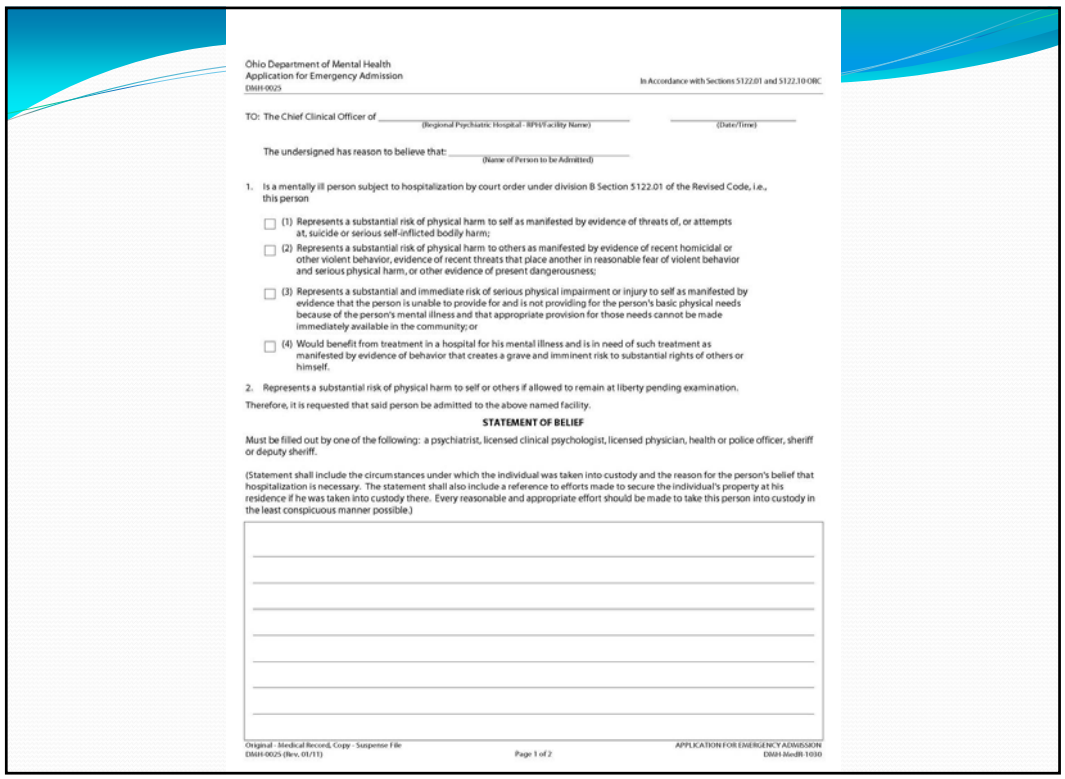
- Daily Roster to CCS with Specialized CIT Officers indicated
- Respond to CIT calls when requested. Seek input of Specialized CIT Officers regarding strategies for crisis resolution
- Report review

Pink Slip – Law Enforcement

- O.R.C. Sec. 5122.10 gives police officers the power to take a person in custody *involuntarily* – and transport to a facility for mental evaluation - *if the individual represents a substantial harm to self or others if allowed to remain at liberty pending examination*
- "Pink Slip" preferred method of admission to hospital for evaluation

Health Authority Emergency Admission

- An officer presented with a pink slip by *an authorized professional* **shall** transport the individual to the designated facility
  - *Authorizing Professional* – Psychiatrist (M.D.),Licensed Clinical Psychologist, Licensed Physician, Police Officer, Sheriff/Deputy Sheriff, County Health Officer– NOT Social Worker, Aide, etc.
  - Must have properly filled out slip, and explain circumstances and reasons for the admission
  - Professional must have confirmed specific facility where the individual will be accepted for evaluation



Ohio Department of Mental Health
Application for Emergency Admission
DMH-0025

In Accordance with Sections 5122.01 and 5122.10 ORC

TO: The Chief Clinical Officer of _____ _____
(Regional Psychiatric Hospital - RPH/Facility Name) (Date/Time)

The undersigned has reason to believe that: _____
(Name of Person to be Admitted)

1. Is a mentally ill person subject to hospitalization by court order under division B Section 5122.01 of the Revised Code, i.e., this person

- ☐ (1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
- ☐ (2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;
- ☐ (3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or
- ☐ (4) Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself.

2. Represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination.

Therefore, it is requested that said person be admitted to the above named facility.

STATEMENT OF BELIEF

Must be filled out by one of the following: a psychiatrist, licensed clinical psychologist, licensed physician, health or police officer, sheriff or deputy sheriff.

(Statement shall include the circumstances under which the individual was taken into custody and the reason for the person's belief that hospitalization is necessary. The statement shall also include a reference to efforts made to secure the individual's property at his residence if he was taken into custody there. Every reasonable and appropriate effort should be made to take this person into custody in the least conspicuous manner possible.)

Original - Medical Record, Copy - Suspense File
DMH-0025 (Rev. 01/11)

Page 1 of 2

APPLICATION FOR EMERGENCY ADMISSION
DMH-MedR-1030

Probate Warrants

- Specialized CIT Officers will serve Probate Warrants
- To be handled in a manner consistent with handling crisis calls

AWOL

- Contact the Hospital individual is AWOL from.
- If Hospital accepts, convey, if possible
- If Hospital does not accept, determine if individual needs psychiatric evaluation.
- Contact MCT for guidance, if necessary

Crisis Intervention Reports/CIT Stat Sheets

- Incident Report with "Crisis Intervention" in the title **and** a CIT Stat Sheet *shall* be completed whenever officers respond to a crisis call
- Even if individual is not arrested or conveyed to a mental health facility – e.g. counseled and referred to an agency.
- If a Specialized CIT officer is on scene, that officer will do reports
- If no Specialized CIT officer is on scene reports will be completed by another officer on scene

CLEVELAND DIVISION OF POLICE
/ CRISIS INTERVENTION MENTAL HEALTH/AOD STATISTIC SHEET

Date: _____ Time: _____ Incident type: _____

Incident # ____ - _____ Location: _____

Requested by: ☐ CCS ☐ Z/C ☐ Family ☐ Case Worker ☐ Fire/EMS ☐ Other

SUBJECT:

Name: _____

Gender: ____ Race: _____ DOB: _____ SSN: (Last 4) _____

Best means of contact/locating: _____

CHECK ALL THAT APPLY:

☐ MH Client ☐ Alcohol/Drug Related ☐ Homeless ☐ Veteran
Was the subject armed? ☐ Yes ☐ No Type of weapon: _____
☐ Injury to Subject? ☐ Injury to Officers? ☐ Injury to others

TOOLS/TECHNIQUES USED:

☐ Verbal De-escalation/Crisis Intervention techniques
☐ Use of Force: ☐ Pain compliance ☐ Take Down ☐ Handcuffs
☐ ASP ☐ OC Spray ☐ Taser ☐ Other: _____

☐ UDFIT notified ☐ RMS Completed

DISPOSITION:

☐ Complaint Unfounded ☐ Information received / advised ☐ Citation issued
☐ Subject/Incident stabilized requiring no further action ☐ Confer w/Mobile Crisis
☐ Conveyed/Transported to (Facility) _____ ☐ By: _____
☐ Voluntary ☐ Non-Voluntary ☐ Probated ☐ Pink Slipped
☐ EMS On Scene? Unit # _____ ☐ Arrested Charge _____

Name/Address of caller: _____
_____

☐ Point of Contact (Case worker, Dr., etc.) _____
_____

☐ Reason for interaction: _____
_____

Any concerns (safety) whatsoever, for this subject (or) address: _____
_____ ☐ CCS Notified?

Supervisor on scene: ☐ Yes ☐ No

Officer(s): Name / Badge # _____ CIT certified ☐
Name / Badge # _____ CIT certified ☐

Please forward this form only -(no staples/reports)- to the CIT Coordinator via Divisional Mail.

Exhibit E

Cleveland Division of Police
Lesson Plan

Title of Lesson: Crisis Intervention Team Response GPO Review

Assigned Course Number: TBD

Author: Captain James Purcell #6568

Date Written: 01/03/17

Approving Authority: PENDING

Overview:

The CIT Response GPO Review is a one-hour long presentation which will be contained in the eight-hour program: "Responding to Crises". The CIT Response GPO Review will contain the following major elements:

1. Understanding the responsibilities of Communication Control Section and the procedures for ensuring the dispatch of a Specialized CIT Officer to the scene of a crisis as soon as possible.
2. Understand the steps to be taken by the first officers on the scene of an individual in crisis And the additional steps to be taken by a Specialized CIT Officer
3. Understand what appropriate de-escalation of Juveniles is and what agency to contact for advice.
4. Identify verbal and tactical de-escalation techniques appropriate for individuals in crisis.
5. Identify appropriate use of force, handcuffing, and diversion/referral options relating to individuals in crisis
6. Identify appropriate transportation of voluntary vs non-voluntary and violent vs non-violent individuals
7. Understand Supervisor responsibilities related to individuals in crisis.
8. Identify the Law Enforcement Emergency Admission "Pink Slip" use and proper format.
9. Understand the procedures related to Health Authority Emergency Admission, Probate Warrant, AWOL, and Requests for assistance from mental health agencies.
10. Understand the use and proper completion of the Crisis Intervention Report and CIT Stat Sheet

Course Goal(s):

The goal of the CIT Response GPO review is to provide students with the understanding of the CIT Response, the individual responsibilities of CDP sections, and the step by step process of dealing with individuals in Crisis.

Course Objective(s):

Upon completion of the Mental Illness Overview participants will be able to demonstrate knowledge of the following:

1. What are the procedures CCS must follow to ensure timely response of a specialized CIT officer to the scene of a crisis.

2. What steps should an officer take after initial assessment of the scene involving an individual in crisis.
3. Who should take primary responsibility for handling a crisis incident.
4. Who should be contacted for advice when handling a juvenile in crisis.
5. What is the difference between verbal and tactical de-escalation techniques.
6. What factors should be considered when determining the use of handcuffs.
7. When Ems is mandated to be called, and when is EMS an option for transport.
8. What is the proper way to fill out a Law Enforcement Emergency Admission- "Pink Slip" and under what circumstances should it be used.
9. What are the circumstances for a Crisis Intervention Report and CIT Stat Sheet to be completed and who is responsible for completing them.l

Methodology:

Participants will be taught by a law enforcement officer . A Powerpoint presentation and a handout of the GPOs will serve as an instructional aids points. The instructors will also use class discussion to increase participant interest and involvement.

Target Audience:

All members of the Cleveland Division of Police

Class Size:

TBD

Evaluation Process:

Participants will complete a post-test which will examine acquisition of key points. Participants will be required to answer at at least 70% correct.

Logistical Information:

Site: Cleveland Police Academy

Training Equipment:

Computer, projector screen and speakers
Powerpoint presentation (electronic)
2 GPOs CIT Program/Definitions (handouts)
Post-test (handout)

Staffing Requirements:

Instructors: One Law Enforcement Officer

Cleveland Division of Police
Lesson Plan

Training Summary:

All assigned participants will arrive at the designated time and go to the designated facility. Participants will receive an overview of the training, performance and learning objectives, and an introduction to the material.

Training Schedule:

0030-0000	Instructors on site
0000-0005	Introduction to the Crisis Intervention Team Response GPO, Class discussion on their current beliefs and understanding of CIT Response in CDP
0005-0010	CCS Responsibilities described.
0010-0020	Responding officer responsibilities described, broken down into initial officer and specialized CIT officer. Group discussion of roles of both with mention of diversion.
0020-0025	Juveniles in Crisis response described. Officers encouraged to call CRT for advice/appropriate facility if necessary.
0025-0030	Verbal and Tactical De-escalation described. Quick synopsis, verbal de-escalation/active listening to receive its own block of instruction.
0030-0035	Use of Force, Handcuffing options described, group discussion on discretion in handcuffing.
0035-0045	Diversion Options & Transportation described, options broken down, Q&A period to ensure full understanding
0045-0050	Law Enforcement Emergency Admission “pink slip” use described, proper pink slip completion demonstrated.
0050-0055	Health Authority Emergency Admission, Probate Warrants, AWOL, Requests from Mental Health Agencies, proper response described.
0055-0100	Crisis Intervention Reports and CIT Stat Sheets describe when mandated, and who is mandated to complete, as well as where they are submitted.
0100	End of Session

Exhibit F

Cleveland Division of Police
CIT Response G.P.O.
Instructor's Manual

Slide 1 – Title

Slide 2 – Our purpose

- Start by asking the group how many are CIT Officers and have received the 40 hour training. What are they expecting from the new GPO's ?
- Why is training on mental illness needed for police officers?

Key points to make

- This guideline is for response to a crisis call at ALL levels. From the dispatchers to all patrol officers, CIT or not, to Supervisors, as well as Probates, Pink Slips and reporting.
- **Crisis**: A situation where an individual's safety and health are threatened by behavioral health challenges, to include mental illness, developmental disabilities, substance use, or overwhelming stressors. A crisis can involve an individual's perception or experience of an event or situation as an intolerable difficulty that exceeds the individuals current resources and coping mechanisms and may include unusual stress in their life that renders them unable to function as they normally would, which may make them a danger to self or others.
- Improving safety of officers and citizens is the top priority.
- Linking people with mental health agencies and steering them from the criminal justice system into mental health system improve longer-term outcomes.

Slide 3 – CCS Responsibilities

- The goal is to have a CIT Officer respond to every crisis call
- This may result in Specialized CIT officers being pulled off lower priority calls.
- Note: Dispatchers are receiving their own training for better response to crisis incident calls. New protocols are being put in place in radio.

Slide 4 – Crisis Incident Response – All Officers

- This is a general guide for response to crisis incident for *ALL* officers, whether CIT trained or not.
- It is effective to read the list to officers, then break it down:
    - Assessment; Safety issues? Does individual have medical issues?
    - Get Specialized CIT Officer to scene.
    - EMS if necessary, especially in case of violent individual or individual in medical crisis. Refer to Video to be shown during Slide 13.
    - Attempts to communicate/de-escalate may give clues to level of communication possible Is the individual processing? Are they responding, in any way, to your voice?
    - Talk to family/friends – Diagnosis? Medications? Other substance Use?

Slide 5 –Specialized CIT Officer Response

- Specialized CIT officers have greater knowledge/training and are expected to use a more nuanced approach.
- Introduce yourself AS a CIT Officer, wear marker.
- Take primary responsibility for the scene. This includes: being the primary communicator with the individual, be aware of tactical space, both for yourself and other officers, remove distractions from the scene.

Slide 6 – Juvenile Response

- Age Appropriate – A child's brain is different from that of an adolescent, is different from that of an adult. All will respond differently, and need different approaches.
- CRT may respond to scene if called or advise appropriate E.R. CRT is more likely to respond to scene than for regular adult Mobile Crisis calls. Juvenile calls are a priority and juveniles in crisis have a different set of resources that may be used by CRT.

Slide 7 –De-escalation

- NOT Use of Force De-escalation. Most individuals we are dealing with are not criminals and not under arrest – not an enforcement action.
- Tactical – be aware of distance, don't use 21 foot rule as a guide. You may need to stay 40, 50 or more feet away to maintain a reactionary gap. Don't resist backing up or expanding your space. "Strategic repositioning" is not retreating, it is enhancing your safety and that of the subject.
- Verbal de-escalation will be covered extensively in Active Listening Module.
- *Doesn't mean force can't be used*. De-Escalation may reduce use of force, but will not work on all individuals in all situations.

Slide 8 –Use of Force

- Take as long as you need on these calls.
- Do not let radio rush you and push a bad situation.
- Time is on your side – Human beings cannot maintain a high level of emotion/agitation for an extended period of time. As emotion decreases, communication tends to increase.
- Be aware that much criticism in Use of Force Incidents comes on the treatment of subjects AFTER the Incident. Be aware of subject's physical position, and any medical needs.

Slide 9 – Handcuffing

- Safety is always Job One.
- Use discretion in handcuffing. Remember that many are not being arrested.
- Consider the individuals history (if known) and level of cooperation in making the decision whether or not to handcuff.
- This topic warrants expanded discussion.

Slide 10 –Diversion & Transport

- Felony/Escalating Misdemeanor vs Misdemeanor Citation/Summons?
- If individual's behavior does not rise to the level of Evaluation/Hospitalization, attempt to find follow-up options with mental health or social service agencies.

Slide 11 –Response: Non-Violent Individuals able to seek care on their own

- Use Resource Cards for referral options. If unsure of an appropriate agency, use Mobile Crisis as a resource.
- Always call agency and give info on person who is being referred.
- Complete Reports EVEN THOUGH YOU ARE NOT TRANSPORTING.

Slide 12 – Resource Card Example

- Hand out cards at this time to District personnel.
- Cards are District-specific.
- Cards are not to be used in a random manner. Officers should be familiar with the agency that they are referring people to and have knowledge that the referral is appropriate.
- Show Video at this time. Use as an introduction to following slides. Review the 3 scenarios.
    1. Non-Violent individual in medical crisis – cooperative (this slide is a good reminder that some individuals in a medical crisis can exhibit what appear to be psychiatric symptoms).
    2. Non-Violent individual in psychiatric crisis – marginally cooperative who *complies when transport options are explored.*
    3. Violent/Suicidal individual – uncooperative, needs both restraining and medical /psychiatric care.

Slide 13 – Response: Non-Violent Individual who needs immediate care.

- Officer discretion is to be used in arranging transport. Some individuals are cooperative but have a fear of riding in the police car If the person does not want to go in the car, explore other possibilities EMS can be an option, as well as a family members or friends car. Meet them at facility if other options are used.
- Reports completed whether you do the transport or not

Slide 14 – Response: Possibly Violent Individual Non Voluntary

- Arrange safe transport to appropriate facility – this is dependent on individual's level of cooperation and volatility. Discuss options with the class to create better understanding of appropriateness.
- EMS will always be called to transport a violent individual. If EMS is unavailable for a period of time, attempt to get an ETA and evaluate options based on behavior/risk to the individual.
- Pink Slip to be completed for individual to be evaluated.
- Complete Reports

Slide 15 – Transporting Violent Individuals

- CPD Officers secure individual – we don't hand over individual to EMS, we assist in securing individual, using handcuffs and restraint system on the cot. One officer always rides with EMS
- Review Video scenario #3 – Individual had to be restrained, needed immediate medical care (slit wrists) and psychiatric care. Restrained to EMS cot by CDP and EMS. Ask for comments from class, clarify any questions about the scenarios.

Slide 16 – Supervisor Responsibilities

- Even though Supervisor may take control of scene, they should ask for input of CIT Officer, and consider letting the CIT officer continue to be the main communicator with the individual in crisis. Discuss this with class.
- Report Review is important. New protocol should result in many more Crisis Intervention Reports and Stat Sheets. Each must be filled out completely and every Crisis Intervention Report should have a CIT Stat Sheet with it. Every officer can do these reports and sheets. They do not have to be CIT trained.

Slide 17 – Pink Slip – Law Enforcement

- In the past, we generally filled out hospital admit forms.. Pink Slip is now the preferred method when bringing in individuals to the hospital involuntarily.
- The preferred person to fill out the pink slip is a specialized CIT officer - Discuss specialized CIT officer's role in the process.
- Pink Slip reduces our liability and underlines the seriousness of the individual's condition.

Slide 18 – Health Authority Emergency Admission

- Discuss with class who an authorized professional is
- Discuss what to do if presented with a pink slip filled out by someone who is not authorized – you will have to do your own evaluation, but can take into account the observations of the complainant. Make sure individual meets the standard for pink slip.

Slide 19 – Pink Slip (Example)

- Review Slip, and emphasize that it must be filled out completely, including check box, and statement supporting boxes that were checked. Discuss standards for the pink slip as per slide 18.

Slide 20 – Probate Warrants

- Specialized CIT officers to serve probate warrantes, but consider using other resources based on the information provided. Do you need additional units, EMS?

Slide 21 –AWOL

- Generally these individuals are from lockdown facilities. Some facilities allow home visits.

Slide 22 – Crisis Intervention Reports/CIT Stat Sheets

- Completed for ALL CRISIS CALLS. Only when a call is found to be not a crisis call should there be no report.
- Can be completed by any officer, but is generally done by the CIT officer.
- 2 Reports are ALWAYS done together.

Slide 23 – New CIT Stat Sheet

- Must be filled out completely.
- Check Boxes/Fill in Blanks. Complete ALL THAT APPLY

Exhibit G

Responding to Crises:

An Overview of Mental Illness and Related Concepts for Cleveland Police Officers

Our purpose

What is mental Illness

Definition of Mental Illness

- A syndrome characterized by **clinically significant disturbance** in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes…[and] associated with **significant distress or disability** in social, occupational, or other important activities.

DSM-5

Substance Use/Addiction

- Myth: Addiction is a character flaw
- Fact: Addiction is a brain disease
- Addiction commonly co-occurs with psychiatric illness leading to:
  - Further complications in diagnosis
  - Exacerbation or masking of psychiatric symptoms
  - Interference with treatment attempts
  - Increased risk of death, homelessness, suicide, incarceration
- Future training will address this important topic in detail
- See handout for additional information

Schizophrenia

- "Split mind" – not multiple personalities
- **Loss of touch with reality**
- Caused by imbalance of dopamine in the brain
  - Too much in the temporal lobes
  - Not enough in the frontal lobes
- Very impairing, but recovery can happen
- Victimization far more common than violence

Schizophrenia

- Core symptom: Delusions
- Fixed false beliefs
- Feels very real to the person
- Paranoid delusions
- Grandiose delusions
- Behavior is driven by beliefs

Potential video: "Delusions " (2 min. male in therapy describing)

Delusions

- [Video played here]

Schizophrenia

- Core Symptom: Hallucinations
- Hallucinations – unreal sensory experience
- Auditory hallucinations
- Visual hallucinations

- Case example

A day in the life of schizophrenia

- [Video played here]

Schizophrenia

- Core symptom: Disorganization
- Disorganized speech
- “word salad”
- Disorganized behavior

Schizophrenia

- Negative Symptoms
  - Not engaging
  - Poverty of speech
  - “Flat affect” – restricted emotional expresion
  - Low motivation
  - Poor grooming and hygiene

- Very impairing and don’t improve with meds

Schizophrenia – treatment

- Antipsychotic medications
  - Block dopamine
  - Can improve delusions and hallucinations
  - Can improve disorganization
  - Make negative symptoms worse
- Work for many, but not for some
- Noncompliance occurs – many reasons
- Side effects can be severe
  - Tardive dyskinesia
  - Diabetes

Mood Disorders

Major Depressive Disorder

Bipolar Disorder

Major Depressive Disorder

- Not simply "the blues"
- Core Symptom: depressed mood or anhedonia
- Additional symptoms:
  - Crying spells
  - Feelings of worthlessness or guilt
  - Appetite, energy and sleep disturbance
  - Psychomotor agitation/retardation
  - Diminished concentration
  - Preoccupation with death
  - Suicidal thoughts, plans or acts

Major Depressive Disorder

- How is it treated?
- Antidepressant medication will be necessary for recurrent forms of MDD
- Noncompliance occurs due to length of treatment and side-effects
- Therapy helps also
  - The role of thinking errors
- ECT can be necessary
- Relationship between suicide and addiction

Bipolar Disorder

- Bipolar Type I = “manic depression”
- Alternating episodes of Major Depressive Disorder, and Mania
- Bipolar Disorder should not be understood to apply to people with rapid mood swings
- Think of depression for months to years, and mania for weeks to months
- Psychotic symptoms can occur

Bipolar Disorder - Mania

- Core Symptom: expansive, elevated mood
- Additional symptoms:
  - High energy
  - Decreased need for sleep
  - Racing thoughts
  - Increased talkativeness
  - Inflated self-esteem
  - Distractibility
  - Impulsive with poor judgment

Bipolar Disorder – treatment

- Mainstay of treatment is a mood stabilizer
- Lithium, Depakote, other antipsychotics
- Noncompliance is common
  - Side-effects can be severe
  - "I'm too slowed down, I'm not creative, I lost my great ideas…"

Borderline Personality Disorder

- Personality disorders develop over the course of childhood, adolescence, early adulthood
- BPD is more common in females
- Associated with abusive childhood histories, particularly sexual abuse
- In general, this is associated with extreme instability in relationships and unstable moods

Borderline Personality Disorder Symptoms

- Extreme emotional reactions, particularly in relationships
- Unstable identity or self-image
- Impulsive actions in multiple areas and that can harm the person (sex, substances, dangerous driving)
- Fear of and frantic attempts to avoid abandonment
- feeling empty inside
- inappropriate and intense periods of anger
- transient paranoid thoughts when stressed and/or dissociative symptoms (such a feeling unreal, memory problems, feeling disconnected from one's own body)

Borderline Personality Disorder

- Self-mutilation (e.g., superficially cutting of wrists is common (about 75%)
  - May be suicidal in nature, in others it helps the person to sooth or calm self
- "Black and white thinking"
- Impulsive sexual behavior may be a problem, placing the individual at risk for victimization
- Medications often - part of overall treatment
- Psychotherapy may help with some symptoms
- Treatment - may not be covered by insurance

Borderline Personality Disorder

- First responders, family and hospital systems may find the person very challenging
  - Person may be well known to police, hospitals
  - Suicidal threats must be taken seriously, even when there is a pattern (3-10% complete suicide)
  - Expressing doubt about true suicidal intent can lead to more intense actions
  - Impulsive or seductive actions could come into play

Borderline Personality Disorder

- For calls to police
  - Communicate that you are there to help
  - Provide a sense of control if possible by offering choices
  - Display confidence, patience, and respect while listening actively
  - Avoid force while remaining vigilant
  - Don't make promises that you cannot keep
  - Do not be drawn into sharing personal information, favors, or taking an action outside of usual procedures
  - Is there someone they can contact to help (friend, family, therapies)
- Mobile crisis unit – if uncertain about need for ER

Posttraumatic Stress Disorder

- The nature of traumatic experiences
  - Inability to escape
  - Direct experience or witnessed
  - Terror
  - Single extreme events vs. multiple events
    - Adverse Childhood Events
- Stress hormones →Fight, Fight and Freeze
- Potential impact on the individual
  - Enduring hormonal changes, cognitive, emotional,
- Posttraumatic stress disorder

PTSD Diagnosis

- Exposure to actual or threatened serious violence/injury
- Intrusions (memories, dreams, flashbacks, reactions to cues)
- Avoidance of things related to the events
  - memories, people, situations
- Changes in arousal and reactivity
  - aggression, destructive, startle, sleep, concentration, hyper-vigilance
- Cognition and mood
  - Negative feelings, beliefs, shame, self blame, detached, can't recall

Posttraumatic Stress Disorder

- Treatment
  - Therapy
    - Exposure, integration, meaning/narrative
  - The role for medications
  - Barriers to treatment
    - Avoidance of therapy
    - Disengagement
    - Mood
    - Shame

Toxic Stress

- Overwhelming stress with biological impact
- Children in poverty- at higher risk
- Abuse, neglect, witness violence
- Estimated for 1 in 7-10 children
- Potential Impacts:
  - Disrupted attachment/a need to focus on survival
  - Impulsivity, reduced attention/concentration, difficulty with trust and accepting help
  - More difficult to understand what or who is a threat
- Key to resilience – a trusted, caring relationship

Later in Life

- May have learned harmful survival skills
- May result ongoing problems in living
- Associations with
  - Medical, mental health and addiction problems
  - Lower threshold for the fight/flight response
  - Dissociation of behavior, knowledge, sensation, emotion
  - Impulsive and high-risk actions
  - Greater risk for problems with school, work, the law
  - Difficulty envisioning a better solutions

Veterans

- Increased risk of suicide (estimated at of 20 per day)
  - 65% of vet suicides from those 50 and older
- Combat training, probable access to a weapon, and the potential impact of their service experience may pose increased risk to an officer
- Developing trust is critical
- Seek to use simple, direct requests vs. lengthy instruction
- Will be covered more in later trainings

Wrap-up

- Q & A

Exhibit H

Cleveland Division of Police
Lesson Plan (version 4/28/17)

Title of Lesson: Mental Illness Overview

Assigned Course Number: TBD

Author: Megan Testa, M.D., Richard Cirillo, Ph.D.

Date Written/Revised 12/9/16, 12/15/16; 2/1/17; 4/28 17

Approving Authority: PENDING

Overview:

The Mental Illness Overview is a 2 ½ hour-long presentation which will be contained in the eight-hour program: "Responding to Crises". The Mental Illness Overview will contain the following major elements:

1. Understanding the nature of mental illness including that it takes multiple forms, the significance of it in the lives of individuals, families and society, and that understanding mental illness takes study, practice and discussion
2. Identify behaviors and key symptoms which are indicative of Schizophrenia and understand the major treatment approach to schizophrenia as well as barriers to effective care.
3. Identify behaviors and key symptoms which are indicative of Major Depressive Disorder, the major approaches to treatment, and factors related to suicide.
4. Identify behaviors and key symptoms which are indicative of Bipolar Disorder and how it is treated.
5. Brief overview of Borderline Personality Disorder and the challenges which it can present to law enforcement
6. Identify the behaviors and symptoms related to Posttraumatic Stress Disorder as well as the enduring behavioral and health impact of stress on children, adolescents and adults.

Course Goal(s):

The goal of the Mental Illness Overview is to provide participants with enough knowledge and awareness to identify the likelihood of a severe mental illness or behavioral disturbance that has a strong likelihood of being attributable to a severe mental illness.

Cleveland Division of Police
Lesson Plan (version 4/28/17)

Course Objective(s):

Upon completion of the Mental Illness Overview participants will be able to demonstrate knowledge of the following:

1. Mental illness takes many forms and impacts individuals, families, and the broader community
2. Behaviors suggestive of Schizophrenia and identify appropriate intervention techniques
3. Behaviors suggestive of Bipolar Disorder and identify appropriate intervention techniques
4. Behaviors suggestive of Major Depressive Disorder and identify appropriate intervention techniques
5. Behaviors associated with Borderline Personality Disorder and the challenges which it can present to law enforcement
6. Behaviors suggestive of Posttraumatic Stress Disorder and identify appropriate intervention techniques
7. The impact of stress on children, adolescents and adults and how that impact can challenge law enforcement.
8. Basic overview of veterans issues including reference to difficulty with re-adjustment to civilian life, mental illness, suicide rate, and risks to officers
9. Ways in which addiction can complicate treatment and exacerbate problems

Methodology:

Participants will be taught by a pair of instructors: a law enforcement officer and one mental health professional. A power point presentation will serve as an instructional aid and will include short video examples as well as basic outlined points. The instructors will also use class discussion to increase participant interest and involvement.

Target Audience:

All members of the Cleveland Division of Police

Class Size: TBD

Evaluation Process:

Participants will complete a post-test which will examine acquisition of key points. Participants will be required to answer at at least 70% correct. In addition, instructors will have the option of supplementing the evaluate in the event that there is an unwillingness to attend to the material and/or participate at a meaningful level.

Logistical Information:

Site: TBD

Training Equipment:

Computer, projectors, creen and speakers
Power point presentation (electronic)
Power point presentation (handout)
Post-test (handout)

Cleveland Division of Police
Lesson Plan (version 4/28/17)

Staffing Requirements:

Instructors: One Law Enforcement Officer and one Mental Health Professional

Training Summary:

All assigned participants will arrive at the designated time and go to the designated facility. Participants will-received an overview of the training, performance and learning objectives, and an introduction to the material.

Training Schedule:

-0030-0000	Instructors on site
0000-0005	Introduction to the Mental Illness Overview training
0005-0010	Class discussion on their current beliefs and understanding of mental illness and the definition of mental illness
0010-0015	Brief introduction to addiction and related issues
0015-0025	Schizophrenia introduced as a topic and delusions described and discussed. Delusions video played
0025-0040	Hallucinations described, and the "A day in the life of schizophrenia" video (4 min) watched and discussed
0040-0045	Negative symptoms of schizophrenia described
0045-0055	The use of medications is described including the role of dopamine, the improvement that can be expected, the nature of side effects and the problem of non-compliance
0055-0105	BREAK
0105-0112	Major Depression core symptoms identified and discussed
0112-0120	Medications, ECT and the relationship between mood and statistics related to suicide
0120-0130	Bipolar disorder introduced and the concept of mood swings
0130-0140	Discussion of mania and the treatment of bipolar disorder
0140-0150	Introduction to Borderline Personality Disorder (BPD) and key symptoms
0150-0200	Challenges and techniques in responding to calls situations with BPD
0200-0203	Traumatic experiences and the relationship to Posttraumatic Stress Disorder (PTSD)
0203-0206	The core symptoms of PTSD
0206-0212	The nature of adverse childhood events, stress/trauma and enduring impact on mood, emotional control, and overall health
0212-0220	Veterans issues and mental health/suicide/danger to officers
0220-0230	Post test

Exhibit I

Cleveland Division of Police
Mental Illness Overview
Instructor's Manual (version 4/28/17)

Slide 1 – Title

Slide 2 – Our purpose

- Start by asking the group to explain what they know about this training. What are they expecting? What have they heard?
- Why is a training on mental illness needed for police officers?

Key points to make

- You will routinely encounter people with various special needs including mental health problems, addictions, developmental disabilities, and those who are in various levels of distress
- Understanding those special needs will help you to respond in a manner that improves the chances for a safe and positive outcome for both you and those that you are responding to
- Understanding mental health and other special needs populations requires some study, practice and discussion – it cannot be done just on instincts
- To effectively respond to the complex needs of those in crisis requires elements of sound policing technique as well as knowledge of crisis response and special needs populations

Slide 3 – What is mental illness?

- Start by getting them comfortable speaking in the class/develop some interest
- What do you picture when you think of mental illness?
- How many know or know of someone what has experienced mental illness? What did it look like?
- How would you define it for a friend?

Key points:

- Mental illness takes many forms
- In one way or another all of our lives have been touched by it
- Our taxes help to pay for identification and treatment
- The United States Surgeon General talks about the "burden of disease" – the number of lost years of healthy life due to death or disability
- Burden of Disease for mental illness is second only to Cardiac Diseases.
    - MI accounts for 15% of all BD – more than all forms of cancers combined.

Slide 4 - Definitions

- Providing this definition to officers can help them start to understand that to be diagnosed with a mental illness, an individual must have a full syndrome, a complete combination of symptoms that impairs cognition, mood or behavior, and that causes impairment.
- It is effective to read this to officers, then break it down:
    - Mental illness is a cluster of symptoms that cause
    - Clinically significant disturbances, and

- Impaired functioning - leading to disability.

Slide 5 – Substance Abuse and Addiction

- The US government (Subtance Abuse Mental Health Services Administration – SAMSHA) estimated (2014) that 7.9 million adults in the United States were dually diagnosed (mental illness and addiction)
- Ideally treatment is integrated with attention to both conditions being given simultaneously – it is not unusual, however, for a person to be only treated for one of
- Emphasize that early detection and treatment will improve outcomes per SAMHSA
- Per the slides note that Addiction is not a character flaw but is now considered a brain disease
- Addiction further complicates diagnosis of mental health conditions
  - Can exacerbate or mask of psychiatric symptoms leading to misdiagnosis or wrong treatment
  - Interference with treatment attempts
  - Increased risk of death, homelessness, suicide, incarceration
  - Future training will address this important topic in detail

Slide 6 – Schizophrenia

- The instructors should explain that the term "schizophrenia" means "split mind" and it is used to describe how the mind splits off from reality in this illness.
- Make sure audience does not confuse this with split personalities, that is not schizophrenia and it will not be covered here.
- Drive home to that Schizophrenia is a LOSS OF TOUCH WITH REALITY.
- It is caused by an imbalance of dopamine – too much in the temporal lobes and not enough in the frontal lobes.
- Let people know that the disorder is very severe, but people can recover through a combination of medications and psychosocial rehabilitation.
- Next hallmark symptom is disorganization – when the persons speech is impossible to understand because the ideas do not connect, "word salad," or the behavior is completely non-sensical,
- Emphasize that people with Schizophrenia are FAR more likely to be victims of violence than perpetrators of violence.

Slide 7 – Schizophrenia

- The first hallmark symptom is that of delusional beliefs.
- Ask the participants to think of anything that they know of to be true – Explain that this is how a delusion feels to a person with Schizophrenia.
- It is not effective to try an convince the person that they are wrong when they have a delusion. It would be like trying to tell a participant that what they know is really not true.
- Types of Delusions
  - Paranoid delusions – Ex. The FBI is following me, my wife is poisoning me, etc.
  - Grandiose delusions – Ex. People believe they are God, Allah, a famous person, or very wealthy

- Explain that people will behave in accordance with their delusions. However, do not use a story about a patient acting violently – it increases stigma and fear.

Slide 8 – Delusions

- Brief video of a clinical interview with a delusional man
- Point out the degree to which he is convinced of his story, the fear which he seems to have related to the content of his belief
- Note the thought blocking that occurs – another symptom of schizophrenia
- Note the bizarre nature of his delusions – "they have a transmitter tuned into my brainwaves"

Slide 9 – Schizophrenia

- Hallucinations are unreal sensory experiences.
- Emphasize that any sense can produce a hallucination but in Schizophrenia there are two most common types of hallucinations:
  - Auditory hallucinations – hearing voices, the voices sound real just as your voice sounds to the audience
  - Visual hallucinations – more rare than hearing voices, typically will be shadows/figures
- Explain that people have hallucinations because of the excess of dopamine in the areas of the brain that process hearing and other senses. Their senses fire even without sensory input. It feels just as real as a sense anyone without Schizophrenia would experience!

Slide 10 – Video: A day in the life of schizophrenia (4 min)

- Explain that the video is a depiction of the experience of schizophrenia from the point of view of the individual
- The video is based on the descriptions of actual people with schizophrenia
- After the video point out the presence of multiple voices, very negative or alarming in tone and message and the relentless nature of the criticism and statements being made to the person
- Emphasize the ways in which the voices might make it hard to follow simple daily living steps as well as interfere with medication adherence

Slide 11 – Schizophrenia

- Explain that another hallmark of schizophrenia is disorganization
  - The person's speech may be impossible to understand because the ideas do not connect together well or logically ("word salad")
  - The person's behavior may seem nonsensical – it may not fit with the situation or purpose and cannot be expected to achieve any reasonable goal

Slide 12 – Schizophrenia

- This slide focuses on "negative symptoms"
- Explain that people with Schizophrenia don't interact with others the way you would expect a person to do so.
- They often don't engage, don't communicate a lot. They don't display the range of emotions that people without Schizophrenia show.
- They often don't have motivation and drive.
- This is due to having a chemical imbalance in the frontal lobes of the brain and medications do not improve negative symptoms.
- These symptoms most impair ability to work and have relationships.

Slide 13 – Schizophrenia - Treatment

- This slide focuses on treatment for schizophrenia
- Let participants know that medication is absolutely necessary in schizophrenia, but it doesn't fix everything and for some who are "treatment-resistant" it doesn't work.
- Medications block dopamine, so they help some symptoms, make others worse.
- Noncompliance is common – many times at no fault of the client. Sometimes meds are too expensive, insurance lapses, etc. Sometimes the person doesn't think they are ill and doesn't think they need meds. None of us would take meds for a condition we did not believe we had!
- Sometimes people cannot tolerate side effects.
- There is much more to treatment of schizophrenia than just meds, including case management, psychosocial rehabilitation, housing support, work support, etc!

Slide 14 – Mood Disorders

- Explain that we will now move on to discuss major disorders of mood
- As with Schizophrenia, the mood disorders described here are considered to severe disorders and can have a profound impact on all aspects of a person's life

Slide 15 – Major Depressive Disorder

- Emphasize that in MDD the mood is depressed all day, every day, or the person has a complete and total lack of interests, called anhedonia.
- It is not simply some sadness or occasional or fleeting sadness. It is persisting and relentless depressed mood.
- Additionally, people with MDD have to have a cluster of symptoms including those listed in the slide
- Explain that many people with MDD have the recurrent form, and that a person who has two separate episodes of major depression has a greater than 90% chance of having a 3rd, 4th, 5th, etc. episode without lifelong treatment.

- The brain is different in MDD – many neurochemicals are involved, including serotonin, norepinepherine and dopamine.

Slide 15 – Major Depressive Disorder (continued)

- Lead a discussion:
  - a) How is this distinct from non-clinical mood problems?
  - b) How those with the diagnosis might appear to an observer
  - c) How do those with the disorder describe the experience of a MDD (loss of energy, interest, feeling extreme sadness/hopelessness)

Slide 16 – Major Depressive Disorder

- This slide focuses on treatment
- Let audience know that antidepressants are absolutely necessary for people with recurrent MDD or depression will keep coming back over and over.
- Goal in treatment with a doctor is to find a medication that the person likes and that doesn't cause bad side-effects, and then continue it as long as possible.
- Noncompliance is common – first reason is that meds take 4-6 weeks at each dose to work, and dose adjustments are required. So – it takes three months or longer to get a good trial on an antidepressant. Some people give up.
- Other people stop the meds when the depression resolves, they figure they don't need it anymore, but depression returns.
- Side-effects are less severe than with antidepressants but still do occur. Weight gain and sexual side-effects are the biggest ones that lead to people stopping their antidepressants.
- When people are treatment resistant, ECT can help them. It is stigmatized and sometimes people won't do it even though it can be lifesaving.
- Lead a discussion regarding treatment - how do people seek out treatment and the barriers
- Presentation of common thinking errors in depression and relationship to therapy
- Brief discussion of statistics and relationship to suicide

Slide 17 – Bipolar Disorder

- We'll focus on Bipolar Type I disorder which used to be called "manic depression".
- There are other variants of bipolar disorder, but officers should focus on understanding true type I bipolar.
- The key features are alternating episodes of MDD and mania, not moment to moment mood swings or people flipping out or people having multiple personalities.
- Ask officers to remember that in Bipolar Type I, people have months to years of depression followed by weeks to months of mania. People with bipolar spend most of their lives depressed!
- Psychotic symptoms can occur in either mood state and are usually "mood congruent" meaning they match the mood.
- Manic people have grandiose delusions, depressed people hear voices telling them they are worthless, or suggesting they commit suicide.

Slide 18 – Bipolar, mania

- When describing mania, make sure people understand the mood must be high, very high, people are "on top of the world," for no reason whatsoever, and they stay like that for weeks.
- While in that mood state, people have the additional symptoms for at least 5 days.
- Emphasize how dramatic this is - people do not sleep for days on end with extremely high energy, high activity, running nonstop.
- I usually explain to audience that when a person is manic their head is filled with ideas, they all sound awesome, the person thinks that they can do all the ideas, and there is not a thought in the person's mind that it might not work out. This drives the poor judgment.

Slide 19 – Bipolar, treatment

- People will need life-long medications to stabilize the mood. The meds knock the highs down and bring the lows up to even things out for people with bipolar.
- Lithium, depakote and antipsychotics are most often used.
- The medications can be hard to use – doctors have to watch for kidney and thyroid damage when using lithium, and have to watch for liver damage when using depakote.
- Remember that antipsychotics can cause either tardive dyskinesia or diabetes or both.
- When the meds work and are tolerated, it is life-changing. But some people are treatment-resistant.
- Noncompliance is common.
    - Sometimes due to insurance, cost, etc.
    - Sometimes due to side-effects.
    - Also, in bipolar, some patients miss having mania, they lower or stop meds to get some of that feeling back.

Slide 20 – Borderline Personality Disorder

- Explain that personality disorders are believed to develop over time as the person moves from childhood to adulthood.
- Personality disorders come in different forms but all are believed to be resistant to change because they represent years of learning and development
- BPD is more common in females than males
- Associated with abusive childhood histories, particularly sexual abuse

Slide 21 – BPD Symptoms

- Briefly describe each of the following
    - Extreme emotional reactivity – often related to relationship problems
    - Unstable identity or self-image,

- Impulsive actions in multiple areas and that can harm the person (sex, substances, dangerous driving)
- extreme fear of and attempts to avoid abandonment,

Slide 21 – BPD Symptoms (continued)

- feeling empty inside,
- inappropriate and intense periods of anger,
- transient paranoid thoughts when stressed and/or dissociative symptoms (such a feeling unreal, memory problems, feeling disconnected from one's own body)

Slide 22 – BPD

- Discuss the common occurrence of Self-mutilation and give examples such as cutting, scratching, burning self
- Note that while often thought of as suicidal, can also be an attempt to sooth self
- "Black and white thinking" is common - someone is viewed as all good or a "savior" at one point only to then later as extremely uncaring or bad if needs aren't met.
- Discuss potential for impulsive behavior (drugs, driving sex etc) placing the individual at risk for victimization
- Medications will usually not address the core symptoms of a personality disorder
- Note that psychotherapy can help with some symptoms (suicidal actions)
- Not all can find it or afford it treatment - may not be covered by insurance companies

Slide 23 - BPD

- Often challenging and frustrating for first responders, family and hospitals
  - Person may be well known to police, hospitals
  - Suicidal threats must be taken seriously, even when there is a pattern
  - Rates of completed suicide with this group range from 3-10%
  - Expressing doubt about true suicidal intent can lead to more intense actions
- Depending on the circumstances seductive behavior could come into play

Slide 24 - BPD

- For calls to police – the mobile crisis unit is a good resource to aid in determining if a trip to an ER is indicated as well as help with needed linkage
- When possible, help the person establish a sense of safety and control
  - Communicate that you are there to help
  - Provide a sense of control if possible by offering choices
  - Display confidence, patience, and respect while listening actively
  - Avoid force while remaining vigilant
  - Don't make promises that you cannot keep
  - Do not be drawn into sharing personal information or taking an action outside of usual policy and procedures

Slide 25– Posttraumatic Stress Disorder

- The inability to escape/loss of control is a key to experiencing a posttraumatic reaction

- Evolution prepared us to be able to fight intensely or flee in the face of serious danger
- A chain reaction from recognition of the threat to stress hormone release, to bodily changes to prepare us for flight or flight

Slide 25– Posttraumatic Stress Disorder

- During fight or flight we respond more instinctually, our higher cognitive abilities are relatively silent during this period
- Impacts the brain's ability to make sense of the event and memory can be impacted –
- In some will get lasting changes in stress hormones even after the trauma has passed

Slide 26 – PTSD Diagnosis

- Describe how with PTSD a person has experienced or were exposed to a highly traumatic or stressful event related to serious injury, death, or sexual violence. This can include learning that such events happened to a family member or close friend. Can also be from repeatedly being exposed to details of horrific events involving death, child abuse, or similar occurrences. Particularly relevant to police officers as they accumulate these experiences over years.
- Note that different types of intrusive experiences can then be had by the individual. Examples include nightmares about the event, flashbacks where the person feels as though they are back re-experiencing the event, having powerful physiological reactions (rapid heart beat, sweating, panic) to cues that might resemble the event – for example the smell of the cologne from a rapist, the smell of gasoline following a horrible care accident.
- Briefly describe the avoidance of things related to the traumatic event, changes in reactivity and arousal as with numbing and hyper-reactive startle response.
- The person may experience cognitive changes with negative feelings, guilt, a sense of being detached from the world.
- Disturbance is more than a month
- Note that Lasting changes in stress hormones may lead to later problems in arousal
- Might takes less for the person to enter into flight or fight again
- Recent war vets with mild TBI = 48% with PTSD
- Substances, disordered eating, gambling, sib, compulsions might all be attempts to re-regulate emotions.

Slide 27 – PTSD treatment

- Emphasize the pervasive impact that PTSD can have on a person.
- Shame, disconnection from life, inability to fully experience joy
- Antidepressants often part of the treatment regimen
- Talk therapy – Work to "expose" the events gradually to direct awareness and discussion
- Allow fragmented experience to become part of the "life story"
- Mention of Veterans and suicide statistics

  - Approximately 22 suicides per day from Afghanistan and Iraq wars
- Does not have to be from war or extreme natural disasters
- Mention of reliance/protective factors with an emphasis on having had the benefit of a caring/protective adult during childhood – buffer to traumatic or toxic stress.

Slide 28 – Toxic Stress

- Research shows that kids from all walks of life can be exposed to adverse events which can impact their health and well being throughout their life
- Kids living in poverty are at particular risk for abuse/neglect/witness to violence
  - In extreme cases may learn that cannot trust adults for safety or comfort
  - Task becomes one of surviving in a chaotic and dangerous world
- These experiences impact the functional connectivity (learning) within the brain
- May interferes with normal learning and brain development
- Such brain changes can lead to cognitive and behavioral problems: impulse control, concentration, ability to trust others, reduced ability to take pleasure or comfort from others, difficulty distinguishing what is a true threat
- Results in higher risk for health problems, contribute to increased problems in school, vocation, and with the law
- Think of kids in this situation as having been injured, not just bad
- No simple solution - but one requirement is for kids be able to feel safe

Slide 29 – Later in Life

- Severe problems with childrearing and toxic stress early in life can impact the ability to feel safe and connected with others
- Increased risk of being victimized, of having health and mental health problems, and of social/vocational problems
- Better to think in terms of what has happened to a person, not what is wrong with them
- Key to resilience – having a trusted, caring person in one's life - a buffer between self and the world
- It might not be a parent, it might be a friend, a relative, a teacher – even a police officer

Slide 30 – Veterans

- Note that the extraordinary experience of serving in the military as well as challenges which can ensue upon returning to civilian life are well recognized as creating great risk for mental health and/or readjustment challenges
- Posttraumatic stress disorder is one but certainly not the only difficulty faced
- Addictions, mood disorders, and difficulty adjusting to the challenges of civilian life can all take a toll
- Note the increased risk of suicide (estimated at of 20 per day) for veterans
- Per the slide note that combat training, probable access to a weapon, and the potential impact of their service experience may pose increased risk to an officer

- Developing trust is critical – We will be discussing methods for communicating and developing rapport in a later module.
    - Will be particularly critical for working with veterans
- In general, seek to use simple, direct requests vs. lengthy instruction

Slide 31 – Wrap-up

- Questions
- Post-test

Exhibit J

Communicating and active listening:

An Overview of What Active Listening is and How to Use it for Cleveland Police Officers

Our purpose

Case Law

Case Law

Case Law Has Been Established Stating That Officers **MUST** Consider the Subject's Mental Health When Using Force.

Griffith v. Coburn

It cannot be forgotten that the police were confronting an individual whom they knew to be mentally ill . . . even though the Officers may not have known the full extent of his autism and his unresponsiveness.

Griffith v. Coburn

The diminished capacity of an unarmed detainee must be taken into account when assessing the amount of force exerted.

Deorle v. Rutherford

"Where it is or should be apparent to the officers that the individual involved is emotionally disturbed, that is a factor that must be considered in determining the reasonableness of the force employed"

How do we normally gain information?

- Ask Questions
- Interview and Interrogation
- Investigations

Characteristics of Traditional Law Enforcement Questioning

- Rapid Fact Finding
- Quick Problem Solving
- Intrusive
- Focus on the Officers Agenda
  - "Just the Facts"
  - Control

Impact of Traditional Law Enforcement Questioning

- Diminishes Rapport
- Creates Pressure
- Can Provoke Defensiveness
- May Create Barriers

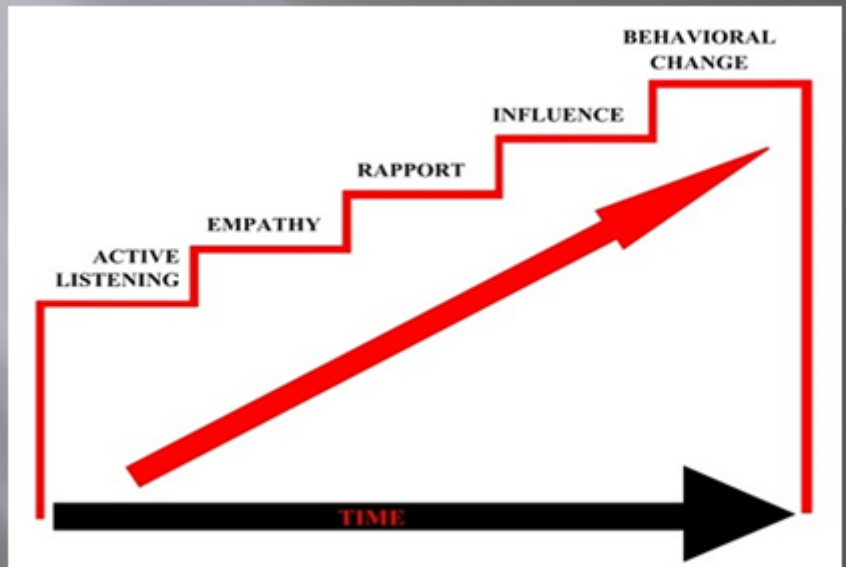


Fig. 2. Behavioral change stairway.

Persuasion vs. Influence

- Persuasion is presenting a case in such a way as to sway the opinion of others, make people believe certain information, or motivate a decision.
- Influence is having a vision of the optimum outcome for a situation and then, without using force or coercion, motivating people to work together toward making the vision a reality.

Persuasion vs. Influence

- Persuasion is More of a One Time Action

- Influence Lasts Longer and May Have Greater Positive Impact.
  - You Persuaded me to Enroll in College.
  - You Influenced me to Study Hard and Graduate.

Build Rapport

- Rapport is a Close and Harmonious Relationship in Which the People or Groups Concerned Understand Each Other's Feelings or Ideas and Communicate Well.

Build Rapport

- Building Rapport Creates Influence
  - Influence Can Cause a Change in a Person's Thoughts or Actions.

Build Rapport

- How to Build Rapport
  - Use Active Listening Skills
  - Show Empathy

Build Rapport

- Phrases That Damage Rapport
  - Calm Down
  - I Understand
  - Why ?
  - You Should / You Shouldn't

Empathy

- Identifying and Understand Another Person's Situation, Feelings, and Motive.

Empathy

- Does Not Mean You Feel the Same Way
- You Just Understand Their Feelings
- Helps Build Rapport and Influence

8 Active Listening Skills

- Emotional Labeling
- Paraphrasing
- Mirroring /Reflecting
- Summary
- Open Ended Questions
- Minimal Encouragers
- Effective Pauses
- “I” Messages

Active Listening is NOT…

- Advice
  - Not Your Ideas
  - Let Subject Have Their Own Ideas

Active Listening is NOT…

- Judgement
  - Not Your Values
  - You May Not Share the Same Values

Active Listening is NOT…

- Persuasion

Emotional Labeling

- State the Emotion That You Hear
  - You Sound
    - Sad
    - Angry
    - Depressed
    - Excited
    - Confused
    - Overwhelmed

Emotional Labeling

- Subjects May Not Understand Their Emotions
- Some Subjects May Be Misleading With Their Emotions
  - Laughing When Sad or Angry
  - Crying When Happy or Excited

Paraphrasing

- Put Meaning in Your Own Words
- Used for Brief Confirmations of Meaning
- Displays Attentiveness

Paraphrasing

- Just Because You Paraphrase a Subject's Statement Does Not Mean You Agree With It.
- You Are Just Ensuring the Subject That You Are Listening.

Paraphrasing

- Subject – “He Got All Up in My Face”
- Officer – “He Confronted You”

Mirroring / Reflecting

- You Repeat the Last Few Words
  - Subject - “She Doesn’t Pay Attention and It Makes Me Angry”
  - Officer - “It Makes You Angry…”

Mirroring / Reflecting

- Can Be Used To
  - Demonstrate Understanding
  - Encourage Subject to Keep Talking

Summary

- Periodically Covering the Main Points
- Tell Back the Story in Your Own Words
  - "So, What You've Told Me So Far…"

Open Ended Questions

- Questions that Require More Than a "Yes" or "No" Answer
  - "What Happened Today"
  - "How Would You Like This to Workout"

Open Ended Questions

- Conveys a Sincere Interest in Gaining Understanding
- Gives a Freedom of Response While Framing the Scope
- Limits the Feeling of Being Interrogated

Open Ended Questions

- Due to Altered State of Mind the Subject May Not Understand or Hear the Question When it is Asked.

- Sometimes the Question Will Need to be Repeated Numerous Times or Rephrased for Better Understanding.

Minimal Encouragers

- Brief Responses or Sounds That Indicate You are Present and Listening
  - Uh-Huh
  - Yeah
  - OK
  - Nodding Your Head (If Face to Face)

Minimal Encouragers

- Best Used When the Subject is
  - Talking Through an Extended Thought
  - Talking for an Extended Period of Time

Effective Pauses

- Uses Immediately Before or After Saying Something Meaningful
- Helps Focus Thoughts

Effective Pauses

- Helps Show the Subject the Conversation is a Turn Taking Process
  - Subject Will Better Understand That They Have a Time to Talk and a Time to Listen.
  - Helps Develop Structure to the Conversation.

"I" Messages

- Used to Confront Uncooperative Behavior
- Used to Confront Without Being Accusatory

"I" Messages

- "When You Do This … I Feel This …"
- "Because of This … I Feel This …"

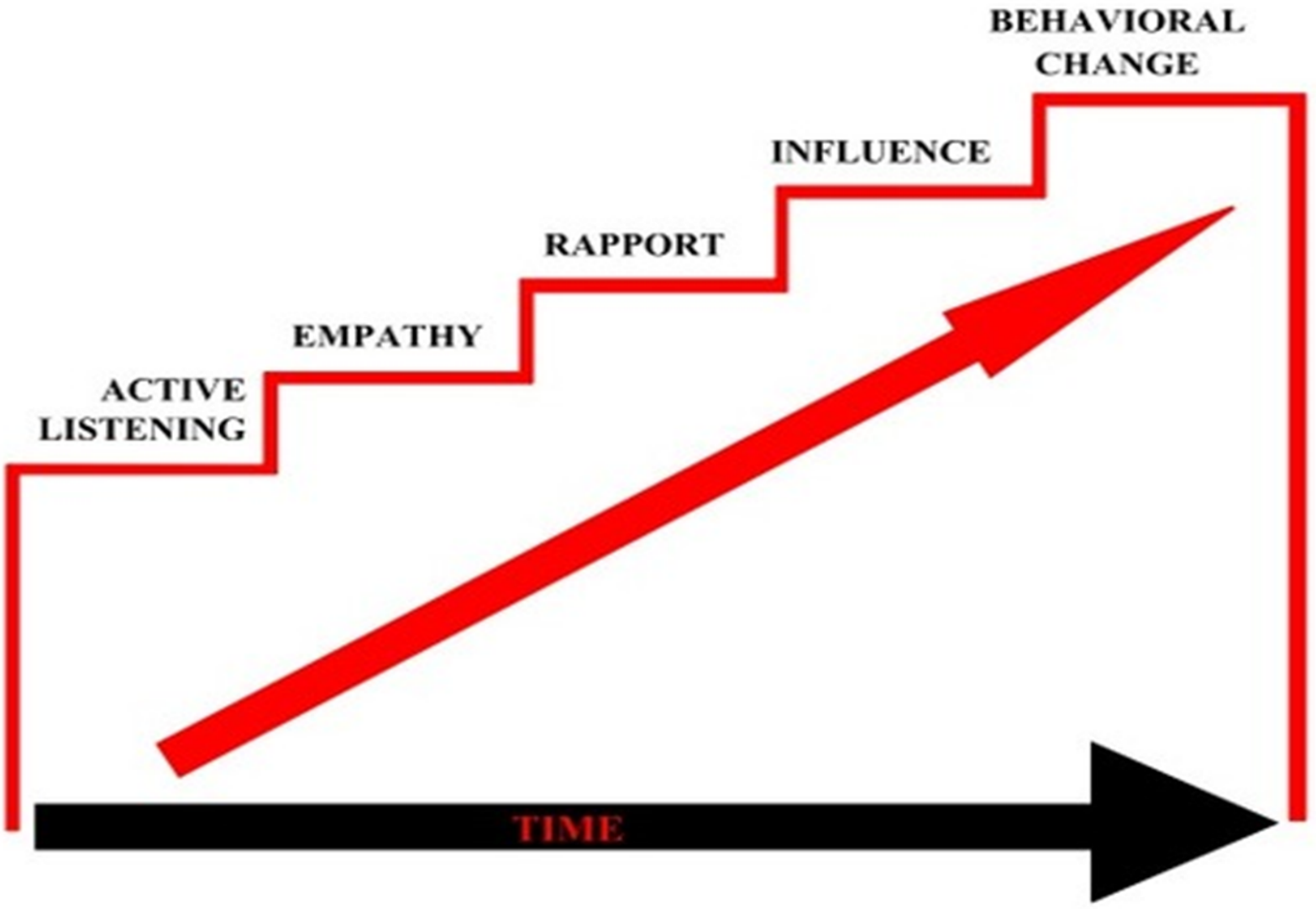


Fig. 2. Behavioral change stairway.

Practice Test

Practice Test Review

TEST

Exhibit K

Cleveland Division of Police
Lesson Plan

Title of Lesson: Communicating and Active Listening

Assigned Course Number: TBD

Author: Det. Jarod Schlacht #2378

Date Written: January 30, 2017

Approving Authority: PENDING

Overview:

The Communicating and Active Listening class is a two-hour long presentation which will be contained in the eight-hour program: "Responding to Crises". The Communicating and Active Listening class will contain the following major elements:

1. Understanding case law that establishes the officer's responsibility and actions when dealing with deescalating an individual in mental / emotional crisis.
2. Identify the characteristics of traditional law enforcement questioning and how these may have a negative impact of an individual in mental / emotional crisis.
3. Understanding the positive impact active listening and rapport building has on an individual in mental / emotional crisis.
4. Identify the 8 active listening skills and how to use them when interacting with an individual in a mental / emotional crisis.

Course Goal(s):

The goal of the Communicating and Active Listening Class is to provide participants with enough knowledge and awareness to use active listening techniques, so they can properly communicate with an individual in mental / emotional crisis.

Course Objective(s):

Upon completion of the Communicating and Active Listening class participants will be able to demonstrate knowledge of the following:

1. Recognize case law governing officer's responsibilities.
2. Recognize the characteristics of traditional law enforcement questioning.
3. Recognize how traditional law enforcement questioning may have a negative impact when dealing with an individual in mental / emotional crisis.
4. Recognize the positive impact active listening and rapport building has when dealing with an individual in mental / emotional crisis.
5. Demonstrate the 8 active listening skills.

Cleveland Division of Police
Lesson Plan

Methodology:
Participants will be taught by a pair of instructors: a law enforcement officer and one mental health professional. A PowerPoint presentation will serve as an instructional aid. The instructors will also use class discussion to increase participant interest and involvement.

Target Audience:
All members of the Cleveland Division of Police

Class Size:
TBD

Evaluation Process:
Participants will complete a post-test which will examine acquisition of key points. Participants will be required to answer at least 70% correct. In addition, instructors will have the option of supplementing the evaluate in the event that there is an unwillingness to attend to the material and/or participate at a meaningful level.

Logistical Information:
Site: TBD

Training Equipment:

Computer, projector screen and speakers
PowerPoint presentation (electronic)
PowerPoint presentation (handout)
Post-test (handout)

Staffing Requirements:
Instructors: One Law Enforcement Officer and one Mental Health Professional

Training Summary:
All assigned participants will arrive at the designated time and go to the designated facility. Participants will receive an overview of the training, performance and learning objectives, and an introduction to the material.

Training Schedule:

-0030-0000	Instructors on site
0000-0005	Introduction to the Communicating and Active Listening training
0005-0015	Class discussion on their current beliefs and understanding of active listening and how it is currently being used.

Cleveland Division of Police
Lesson Plan

0015-0030	Discuss case law, Griffith v. Coburn and Deorle v. Rutherford, and how it impacts law enforcement.
0030-0040	Discussion on characteristics of traditional law enforcement questioning.
0040-0050	Negative impact of traditional law enforcement questioning.
0050-0100	BREAK
0105-0115	Discussion on what active listening is.
0115-0120	Discussion on how active listening builds rapport.
0125-0130	Identify what phrases can damage rapport.
0130-0140	8 active listening skills are identified and discussed.
0140-0145	Communicating and Active Listening class overview.
0145-0150	Communicating and Active Listening class test.
0150-0200	BREAK
0200	End of Session

Exhibit L

Cleveland Division of Police
Communicating and Active Listening
Instructor's Manual

Slide 1 – Title

Slide 2 – Our purpose

- Start by asking the group to explain what they know about this training. What are they expecting? What have they heard?
- Why is training on mental illness needed for police officers?

Key points to make before moving on

- You will routinely encounter people with various special needs including mental health problems, addictions, developmental disabilities, and those who are in various levels of distress
- Understanding how to communicate with the special needs population will help you to respond in a manner that improves the chances for a safe and positive outcome for both you and those that you are responding to

Slide 3 – What is mental illness?

- Start by getting them comfortable speaking in the class/develop some interest
- What do you know about mental health case law concerning law enforcement?

Key points to make before moving on:

- Current case law that governs what we do.
- Know these case laws to assist you in the actions you will take.

Slide 4 – Case Law

- Case Law has been established stating that Officers must consider the Subject's mental health when using force.

Slide 5 – Griffith v. Coburn

- Key points:
  Arthur Partee's mother came to police station to ask about getting a mental evaluation for Arthur. It was found Arthur Partee had an outstanding traffic warrant. Officers responded to Partee's house with mother and entered with permission. Arthur Partee passively sat on the couch watching television, ignoring police orders. Arthur Partee was handcuffed and placed face down on the ground. Arthur Partee stopped breathing. Officers said he was "just faking".Officers performed CPR, but Partee died.

Slide 6 – Griffith v. Coburn

- Discussion:
  - Would a different strategy seem reasonable? If so, at what point?
  - What resources are available to an officer involved in similar situation to that encountered in Griffith v. Coburn?

Slide 7 – Deorle v. Rutherford

- Key points:
  Richard Deorle was upset he was diagnosed with Hepatitis C, consumed a half-pint of vodka and Interferon (medication). Deorle began behaving erratically and became suicidal. Deorle's wife called the police. Officer Mahon arrived and escorted Deorle's wife and kids out of the house, but Deorle would not allow him in the house. Officer Mahon calls for back up. 13 Officers respond, including Officer Rutherford. Officer Rutherford is trained in the deployment of force against recalcitrant suspects. Deorle obeyed police commands and dropped several items, including a hatchet and wood board, when ordered by police to do so. Deorle walked at a regular pace unarmed toward Officer Rutherford. Rutherford did not warn Deorle that he was going to shoot him. Nor did he order Deorle to halt. Officer Rutherford fired his bean bag shotgun, striking Deorle in the eye. Deorle survived, but lost his left eye and had multiple cranium fractures.
- Discussion:
  - How do you evaluate the key factors in this situation?

Slide 8 – How do we normally gain information

- Ask class how they gain information.
  - Ask Questions
  - Interview and Interrogation
  - Investigations

Slide 9 – Characteristics of traditional law enforcement questioning

- Rapid fact finding
- Quick problem solving
- Intrusive
- Focus on the Officers agenda

Slide 10 – Impact of traditional law enforcement questioning

- Diminishes rapport – The emphasis is on getting facts, not establishing conditions which will help the individual to share needed information
- Creates pressure
- Can provoke defensiveness
- Pressure, fear, defensiveness, anger can all contribute to a barrier being created that works against effective collection of information

Slide 11 – Behavioral change stairway

- Discuss with class the behavioral change stairway.
- Point out that the path to behavioral change follows a predictable sequence which begins with a willingness the skill to actively listen.
- Effective active listening will naturally lead to an officers ability to experience empathy – one of the critical aspects of being able to understand, develop rapport with, and then begin to influence an individual
- The ultimate goal is to effect peaceful and cooperative behavior change in the person through this process

Slide 12 – Persuasion vs. Influence

- Discuss with class the difference between persuasion and influence.
- Make the point that a when one can envision a better outcome through communication, self-reflection and thoughtful consideration as opposed to via force, there is a greater likelihood for a lasting and genuine behavioral change.

Slide 13 – Persuasion vs. Influence

- Start a discussion by providing a personal example that contrasts being forced versus having arrived at a desired outcome through communication and reasoning
- Have officers give examples of times when they have arrived at conclusions in their own lives through such a process vs. having been forced into an action.
- How does the outcome differ moving forward?

Slide 14 – Build Rapport

- Discuss with class what rapport is.
- Note that being comfortable with the other person and feeling enough basic trust to share information is a key component
- Emphasize that to have a positive lasting influence on another, building basic trust and comfort in communicating with one another is critical
- Note that in the absence of sufficient rapport between two people, the ability to achieve genuine or lasting influence is greatly reduced

Slide 15 – Build Rapport

- Given example of how a lack of rapport contributes to ineffective interactions and failure to influence another person.
- Have class give examples of when they built rapport with someone and how they did it.
- Use class examples of rapport building to show how they influenced an individual.

Slide 16 – Build Rapport

- Discuss techniques to aid in rapport
  - Discuss active listening including undivided attention, eye contact, paraphrasing back what you have understood, asking for more information, communicating comfort and interest with your body language, expressions and words.
  - Discuss having patience and ability to listen more than speak

Slide 17 – Build Rapport

- Note that once rapport is established it can be damaged easily. For example:
  - Giving commands which they may not be able to comply with (Calm down)
  - Giving a superficial or premature statement that may come across as dismissive in tone such as "I understand" when you clearly don't or have taken the time to understand
    - Depending on how this is said and when, it can be an appropriate response if it follows a period of having really listened to the person and you having demonstrated that you are trying to understand – for example by having paraphrased, and asked for more help to understand
  - Arguing with or debating a persons perceptions
  - Communicating disgust, disinterest, boredom (words, tone and body language all important)
  - Giving advice or trying to talk a person out of their perceptions (telling them "you should or shouldn't" do something)

Slide 18 – Empathy

- Empathy is mostly about feeling a connection to another person
- It should communicate a sense that the officer is:
  - Carefully listening to the person (not bored, impatient, thinking about something else)
  - Concerned for the person and his/her well being
  - Interested in understanding the situation, the feelings the reasons/motive
  - Glad that the concern is being shared even though the officer may not be able to solve all problems

Slide 19 – Empathy

- Discuss that empathy does not mean agreeing with a point of view
  - You can be an empathic and concerned listener without saying that you agree with the person's point of view
- It does not mean trying to point out a "silver lining" in the situation
- It does not involve giving advice or trying to quickly fix a situation for a person
- It is about helping the person feel connected and supported in that moment
- Helping the person understand that you are there for their safety and those around them
- It will help you to influence and achieve a positive outcome

Slide 20 – 8 Active Listening skills

- Introduce the 8 active listening skills – We will be covering each in more detail
  - Emotional Labeling – Helps develop awareness and self-control. Can help to connect with another
  - Paraphrasing – Improves your understanding and can help a person to clarify their own reasoning. Shows you care and want to understand
  - Mirroring / Reflecting – Helps the person feel some validation to their experience, again shows you are interested and want to help
  - Summary – Helps to highlight the key things that are being said and put them front and center
  - Open Ended Questions – Can aid in collecting more meaningful information than simple yes/no questions.
  - Minimal Encouragers – Natural conversation enhancers.
  - Effective Pauses – Help with sharing information and allows a person to communicate, giving them time to think and process information.
  - "I" Messages – Emphasize the personal relationship needed to build rapport.

Slide 21 – Active Listening is not

- Discuss how you're allowing the subject to talk, not advising them on what they should do.
- Advice is not likely to be taking or result an any meaningful influence
- Respect that they have their own ideas and be willing to listen

Slide 22 – Active listening is not

- Talk with the class about not passing judgment, whether you agree or disagree with the subject's views.
- It is inevitable that other's will have a different point of view than your own
- Your job is not to get them to see your point of view or see and admit to the flaws in their own judgment

Slide 23 – Active listening is not

- Persuasion
  - Emphasize that officers are not trying to persuade the person, but instead trying to build rapport and influence person's choices.
  - If you can help the person to believe they've been heard it will increase the chance of a positive outcome
    - A greater likelihood of the person regaining self-control and reducing emotional arousal
    - A greater likelihood of some basic trust in the officer

Slide 24 – Emotional Labeling

- State the emotion that you hear but in a way that respects the individual's own perceptions
    - Example: "It seems that you are very sad right now"
        - Ask the class how they might react if the person said "no you are wrong" in response to the officer's statement in the example
            - Emphasize that feelings or emotions are highly personal and the officer should not try to talk the person into accepting an emotional state if they disagree.
            - In short you can try to help a person identify a feeling, but you cannot tell a person how to feel.
            - An appropriate response to a miss in this area might be to then ask the person to tell you in their own words what they are feeling or going through
    - Ask class to demonstrate emotions and identify them.

Slide 25 – Emotional Labeling

- Note that the person may not understand their own emotions in the moment or be able to
- In some cases outward signs might be inconsistent with what they are feeling inside. For example they may be laughing when feeling sad or angry
    - It is not your job to be a therapist
    - Your goal in this area is to remain vigilant while making an attempt to help the person feel understood and know that you want to help keep them and others safe
    - Emotional labeling can help with this in some cases.

Slide 26 – Paraphrasing

- Discuss with class how to paraphrase statements.
    - Put meaning in your own words
    - Used for brief confirmations of meaning
    - Displays attentiveness

Slide 27 – Paraphrasing

- Note that when you paraphrase a statement doesn't mean you agree with the person
- You are simply trying to understand their point of view
- Effective at expressing empathy as officer has understood what was said.

Slide 28 – Paraphrasing

- Ask for a volunteer to help demonstrate paraphrasing first using their own experience
    - Ask the volunteer to explain some of the reactions that they are having to something that is happening in the news or with a Cleveland sports team. Make sure to have them elaborate a bit – it cannot be just a few words in response.
    - Take the key points made by the volunteer and paraphrase it back. Then ask if that you've captured it correctly
- Now ask for examples from the group of things they've heard from citizens while responding to a call. Ask the officers to then attempt a paraphrase. Do this a few times.
- Give feedback as you go. You are looking for simple, direct and respectful paraphrasing that is meant to communicate understanding while capturing meaning in a way that is more neutral or factual in tone (as with the example on the slide)

Slide 29 – Mirroring / Reflecting

- Discuss with class the meaning of Mirroring / Reflecting
    - You repeat the last few words of the Subject's statement,
- Go over the example on the slide.
- As participants for a few more examples of thinks that individuals have said to them on a call and show how you'd mirror it back

Slide 30 – Mirroring / Reflecting

- Ask the participants why this might be helpful
    - Demonstrates understanding
    - Encourage Subjects to keep talking
    - Helps the person feel some validation to their experience, again shows you are interested and want to help

Slide 31 – Summary

- Discuss with class what summary is
    - Periodically covering the main points.
    - Tell back the story in your own words.
- Ask: Why is this helpful?
    - Helps to highlight the key things that are being said and put them front and center
    - Can help the individual to make better sense of an emotionally charged situation
    - Supports trust and rapport by communicating a desire to understand

Slide 32 – Open ended questions

- Discuss with class what open ended questions are.
    - Questions that require more than a "yes" or "no" questions.

Slide 33 – Open ended questions

- Ask participants: What are the benefits of open ended questions?
  - Conveys a sincere interest in gaining understanding
  - Gives a freedom of response while framing the scope
  - Limits the feeling of being interrogated
  - Can aid in collecting more meaningful information than simple yes/no questions.
  - Encourages thought and dialog
  - Builds rapport and comfort in the interaction

Slide 34 – Open ended questions

- Discuss with class the problems they may face with open ended questions.
  - Altered state of mind
  - Questions may not be understood
  - In such cases will need more structured or guided (yes/no types of questions)

Slide 35 – Minimal Encouragers

- Discuss with class what minimal encouragers are.
  - Brief responses or sounds that indicate you are present and listening
  - Things we often do naturally when we are trying to communicate interest or learn more
- Give examples of minimal encouragers
  - Uh-Huh
  - Yeah
  - OK
  - Nodding your head (if face to face)

Slide 36 – Minimal Encouragers

- Discuss with class the best time to use minimal encouragers.
  - Best used when the subject is
    - Talking through an extended thought
    - Talking for an extended period of time
    - Use on a topic that you are particularly concerned about or want to know more about

Slide 37 – Effective pauses

- Discuss with class what effective pauses are.
- Use effective pauses immediately before or after saying something meaningful
  - Helps focus thoughts

Slide 38 – Effective Pauses

- Discuss with class the benefits of effective pauses.
  - Helps show the Subject the conversation is a turn taking process.
  - Subject will better understand that they have a time to talk and a time to listen.
  - Helps develop structure to the conversation.
- Ask participants for other ways in which periods of silence or pauses might impact conversation and rapport in a positive way
  - Make sure that it is pointed out that pauses allow a person to collect thoughts and continue.
  - Help a person to not feel rushed. Can be used in the officer's own speech to emphasize a statement.

Slide 39 – "I" Messages

- Discuss with class what "I" Messages are and when to use them.
- Effective at creating a personal relationship with the subject
  - Can also be used to address uncooperative behavior
  - Can also be used to confront without being accusatory

Slide 40 – "I" Messages

- Note examples in the slide
- Give example more examples to show how using an "I statement allows the officer to share a concern while building trust and a better chance of cooperation For example:
  - "I am concerned for your safety right now" as opposed to "You stop it now or I'm going to arrest you"
  - "It is important that I understand what is happening here. I need to make sure you are Ok" as opposed to "You're going to stop what you're doing right now and you'll do as I say"

Slide 41 – Behavioral change stairway

- Review the behavioral change stairway again now that all aspects of it have been covered.
- Emphasize to the class that these steps take time, as displayed at bottom of picture.

Slide 42- Practice Test

- Handout practice test.

Slide 43 – Practice Test review

- Review practice test with class.

Slide 44 – Test

- Handout final test.

Exhibit K

Exhibit M

Crisis Intervention: Command and Control Paradox

A module within the 8-Hour Responding to Crisis Course

Purpose

- To understand how to approach a mental health-related crisis call.
- To understand basic principles of de-escalation.
- To understand what the officer brings to the challenge of communication with the public.

"It is the wise officer, who can at times, conceal their combat-ready status"

- Is this true?

Discussion: An Officer's Presence

- What is communicated when a police officer enters a room, restaurant or event?
- What might each of the following suggest?
  - The uniform
  - Posture and body language
  - Stance, eye contact
  - No smile
  - Jaded appearance
  - Loud, commanding voice
  - Rigidity or forceful repetition in speech

Command and Control

- Instructions are given and compliance is expected
- Instruction changes to command when the individual does not comply
- The officer goes to a "hands on" approach if the command is not followed
- In short: "Ask, Order, Make"

Discussion

- When are command and control techniques most appropriate?
- When might they be less appropriate or effective?
- How might the effectiveness of command and control techniques differ in a mental health crisis.

Emotional States in a Mental Health Crisis

A person in a mental health crisis may be experiencing some combination of

- Acute anxiety, panic or fear
- Confusion
- Disordered thoughts or beliefs
- Acute feelings of sadness, despair, hopelessness
- Hallucinations
- General distress

How a Crisis Can Escalate

- Discussion:
  - Think of your own experiences – When frustrated, confused or angry what is helpful, what is not?
  - What about a police officer arriving on the scene might increase the distress of a person having a mental health related issue?

Fight or Flight

- With increasing distress a "flight or flight" response can occur
  - hormonal, bodily and cognitive changes
  - Fast acting, more primitive brain functions activated
  - The brain and body are primed for quick and intense action - increased blood pressure, heart rate, respiration, blood flow to muscles
  - The body is now ready to act, not think or reflect

Fight or Flight

- Survival value when faced with an overwhelming physical threat
  - But…ability to think clearly and respond thoughtfully is reduced
  - Reasoning, careful deliberation, impulse control is less available
    - The person is now action oriented
    - May work against a non-violent conflict resolution
    - Increased likelihood of a sudden and potentially dangerous action
- Goal: Establish safety by lowering emotional arousal
  - Return of ability to think and control actions returns

Impact on the Officer

- Intense bodily and emotional reactions with threat can occur in anyone
- Officers encounter life-threatening situations
- Repeated exposure to high stress may increase the likelihood of powerful reactions to future events
  - Changes in thought and judgment, control of impulses
  - May contribute to an over-reaction or unnecessarily aggressive action
- Work to develop self awareness
- Understand: law enforcement-related stress, like military combat, can have a profound impact on body and mind
- If a pattern of powerful emotional reactions or related problems occur:
  - Not a sign of weakness, a biological reaction to extraordinary experiences
  - Seek out supervision and support as needed

Video Example
De-escalating a mental health crisis

The De-escalation Process

- Goal: Establish safety by lowering emotional arousal
- Introduce yourself and begin to assess the situation
- Communicate confidence, concern, an intention to help
- Remain vigilant
- Show empathy
  - Listen carefully and show you understand by paraphrasing
  - Acknowledge how the situation must be difficult for the person
  - Show interest in the issues
  - Eye contact
  - Patience, slow the process

The De-escalation Process

Seek a Resolution:

- Problem solving
- Who else can the officer contact to help
- Where will the person go for help
- What are the resources being considered
- How will the person get there
- What can the person expect

Role Play

Role Play:

"Call from 911. Person having mental health crisis on West 25th. Interfering with traffic, trying to talk to people, etc. Merchants are complaining"

In Summary

- A command and control approach is not the best approach for a person in a mental health crisis
- De-escalation with ongoing vigilance is the most appropriate choice for a safe and controlled intervention

Closing Thoughts

"Following a mental health crisis, people will always remember how they were treated and felt. The crisis experience will set the stage for future contacts with that person and or situation. "

Post-test

Exhibit N

Cleveland Division of Police
Lesson Plan

Title of Lesson: Command and Control Paradox

Assigned Course Number: TBD

Author: CDP and Richard Cirillo, Ph.D.

Date Written/Revised: 2/10/17

Approving Authority: PENDING

Overview:

The Command and Control Paradox is a 90 minute long presentation which will be contained in the eight-hour program: "Responding to Crises". The Command and Control Paradox module will contain the following major elements:

1. Understanding the unique aspects of a crisis intervention call as it relates to command and control vs. de-escalation
2. Identify the paradoxical aspect of achieving greater control of an mental health crisis situation using a less physical and controlling approach
3. Identify the relationship between acute stress, bodily reactions, and ability to think clearly and control impulses
4. Identify the advantages of de-escalation vs. physical control
5. Identify and discuss key techniques of related to safe de-escalation including but not limited to patience, empathy, active communication and ongoing vigilance.
6. Participate directly or observe other officers in a role play of de-escalation
7. Provide feedback and discussion related to the role-play identifying things which supported a safe de-escalation and those which could have been done differently

Course Goal(s):

The goal of the Command and Control Paradox module is to provide participants with an understanding of the advantages of a verbal de-escalation process during a crisis call and knowledge of the key techniques employed during de-escalation

Course Objective(s):

Upon completion of the Command and Control Paradox module participants will be able to demonstrate knowledge of the following:

1. The differences between a command and control vs. a non-physical, verbal de-escalation approach to crisis intervention
2. The advantages of employing non-physical, verbal de-escalation techniques in a crisis situation
3. The ways in which an authoritative, commanding approach during a crisis can paradoxically result in less control of the situation

4. The practice of vigilance in conjunction with patience, empathy and related techniques as they relate to de-escalation and establishment of basic safety in a crisis situation
5. The role of the fight or flight response in the safe resolution of a crisis

Methodology:

Participants will be taught by a pair of instructors: a law enforcement officer and one mental health professional. A Power Point presentation will serve as an instructional aid and will include short video examples as well as basic outlined points. The instructors will also use role play and class discussion to increase participant interest and learning.

Target Audience:

All members of the Cleveland Division of Police

Class Size:

TBD

Evaluation Process:

Participants will complete a post-test which will examine acquisition of key points. Participants will be required to answer at least 70% correct. In addition, instructors will have the option of supplementing the evaluation in the event that there is an unwillingness to attend to the material and/or participate at a meaningful level.

Logistical Information:

Site: TBD

Training Equipment:

Computer, projector, screen and speakers
Power point presentation (electronic)
Power point presentation (handout)
Post-test (handout)

Staffing Requirements:

Instructors: One Law Enforcement Officer and one Mental Health Professional

Training Summary:

All assigned participants will arrive at the designated time and go to the designated facility. Participants will receive an overview of the training, performance and learning objectives, and an introduction to the material.

Cleveland Division of Police
Lesson Plan

Training Schedule:

-0030-0000	Instructors on site
0000-0005	Introduction to the purpose of the Command and Control Paradox module
0015-0025	Discussion of the impact a police officer brings to a situation and the impact of a command and control approach
0025 – 0030	Class discussion identifying situations where command and control makes sense, and where it may not
0030-0045	Introduction to the role of emotional states in a crisis and fight or flight responses
0045-0055	Video depicting an officer de-escalating a mental health crisis and follow-up discussion
0055-0105	Review of techniques in the de-escalation process
0105-0115	Role play of a de-escalation and follow-up feedback and discussion
0115-0120	Role play using de-escalation with an individual in a mental health related crisis
0120-0130	Summary and closing thoughts
	Post-test

Exhibit O

Cleveland Division of Police
Command and Control Paradox
Instructor's Manual (version 2/7/17)

Slide 1 – Title

Slide 2 – Our purpose

- Start by emphasizing that mental health related crises require an approach that will differ from usual command and control procedures
- This session will involve discussion of:
  - How the officer's presence and approach to the situation can result in further escalation or de-escalation
  - How the brain and body react to threat vs. support
  - How to approach de-escalation in a mental health crisis
  - The ways in which a de-escalation approach can result in greater control and safety during a given call and in future interactions with a given citizen vs. a command and control approach

Slide 3 – It is a Wise Officer…

- Initiate a discussion – Ask the participants: "Is this statement true?"
- Additional points to discuss:
  - Can you look and act friendly and concerned while still being ready for anything?
  - Have officers have been injured or worse because of the treatment the subject got from a previous encounter with another officer who may have had little patience?
  - How might a positive or negative encounter with an officer impact future interactions with law enforcement?

Slide 4 – An Officer's Presense

- Start by asking the group what kinds of thoughts or reactions might people have when an officer enters a room
- Use the bullet points to prompt discussion

Key points:

- The presence of an officer can mean many things to those present depending on their history
  - Control, safety, someone to fear?
  - How might your own way of presenting yourself inpact this?
    - What might a straight face, no emotion, matter of fact approach convey?
    - What might tone of voice, level of eye contact, flexibility vs. rigidity in speech convey?

Slide 5 – Command and Control

- With command and control the emphasis is on quickly gaining control of a situation to establish safety, but not necessarily on communicating a desire to help or understand
- The officer gives instructions based on his/her assessment of the situation and expects that there will be compliance. If not a command is used and finally a hands on to gain control

- Go to discussion

Slide 6 – Discussion

- Have participants share opinions about real world situations where Command and Control makes sense and state why
- Ask for situations where this approach may not be as effective
- What about a mental health-related crisis might make C&C less able to safely gain control of a situation or do so with a minimum of force?
- Lead into discussion on the relevance of emotional states, perceived support, and behavior

Slide 7 – Emotional States in a Mental Health Crisis

- A person in a mental health crisis, by definition, is not able to cope with a given situation as well as when not in a crisis state
- They are unlikely to have as much control over their outward behavior as when in a less agitated state
- Briefly discuss each of the bullet pointed symptoms which the person may be experiencing and note how this can contribute to greater difficulty in self-control and/or responding appropriately to demands of the situation

Slide 8 – How a Crisis Can Escalate

- Start with discussion – We will be focused on learning to increase safety and control by lowering the distress, confusion, frustration of the person
- The presence of a supportive, concerned other is generally recognized as a key element in helping an individual to increase ability to de-escalate and regain a sense of basic control and calm
- In contrast, many other situational factors can have the opposite effect
- How might the following impact a person:
    - Making forceful demands before communicating concern, need to understand
    - Showing complacency – "this is the same drama at this house all the time"
    - A history of the person having had interactions with police
    - The person's own difficulty in thinking clearly, not being able to put thoughts feelings into words, hallucinations, bizarre beliefs, anxiety
    - Family dynamics
    - Cultural issues
- Emphasize that a person's ability to think clearly, accept direction, and use their best problem solving skills depends on their level of arousal
- Too little arousal or concern and a person may not attend to a problem, too much and the ability to think clearly and control actions becomes impaired.

- During a mental health crisis in which a person displays a sense of being upset or overwhelmed, a key goal is to keep or return the level of arousal to a level that allows the person to think as clearly as they are able
- As distress increases, a "flight or flight" type response is more likely to occur

Slide 9 – Fight or Flight

- Fight or Flight refers to a biological process where the body reacts in multiple ways to a perceived threat
- How many have experienced this state – rapid heart beat, raised blood pressure, mind racing, a need to act, feeling "keyed up" or ready to "go off"
- Go through the bullet points with a brief explanation of each

Slide 10 – Fight or Flight

- Emphasize that fight or flight is a normal state under extreme circumstances and that it is the body's way of surviving a perceived immediate and serious threat
- Unfortunately, it may occur even if threat is not necessarily a true life threatening emergency as with extreme instances of frustration or related emotions
- Emphasize that once a person is in this state they are much harder to reason with or control – they are in an Action Mode, not a thinking mode
- Complicating factors
    - Symptoms of mental illness can occur or be exacerbated
    - Lack of insight into what is going on and being asked
    - Possible influence of delusions and hallucinations
    - Fear of the unknown-I need to protect myself
    - Need to save face in the community
    - Previous situations and associations with law enforcement

Slide 11 – Impact on the Officer

- Briefly discuss the high stress nature of police work
- Note the parallels to military service
- It has been estimated that an officer experiences from 10 to 900 situations in a career that could be considered traumatic of severely stressful
    - *(Rudofossi 2009, cited in Andersen and Papazoglou, International Journal of Emergency Mental Health and Human Resilience, Vol 17, no 3, 2015)*
- The same biological processes can and do impact officers
- As with military – can lead to serious impact on the body as well as the ability to react in the moment with the usual level of skill
- Review each bullet point
- Normalize the possibility of such impact on an officer and the need to seek out support and supervision accordingly as part of the job

Slide 12 – Video of an officer visit to a distraught man in his home

- Ask officers for reactions
- What did they notice about the individual? (Upset, hallucinating, response to the caring tone of the officer)
- What about the officer's response seemed to work well? (Patience, body language, introducing self, empathy, communicating a desire to help etc.)

Slide 13 – The De-escalation Process

- Review each bullet
- Emphasis on patience, vigilance, communicating a desire to help

Slide 14 – The De-escalation Process

- Review each bullet point
- Emphasize respect, patience, a problem solving approach when possible
- Inquire as to family that can help?
- A case manager or counselor on call for the person?
- If a person has a place to go how will he get there?
- Question of hospitalization need – Call to Mobile Crisis Unit?
- Share what will be happening next

Slide 15– Role Play

- Call from 911. Person having mental health crisis on West 25th - interfering with traffic, trying to talk to people, etc. Merchants are complaining
- Have instructor play mildly distraught and confused adult
    - Apparently reacting to delusions related to his thoughts being broadcast through the internet
- Have participant play role of officer responding to the call
- Follow-up discussion
    - How does the volunteer approach the scene?
    - How did he/she communicate-verbally and non verbally?
    - How did it differ from usual command and control
    - Did anyone observe any safety issues that may have needed to be resolved?
    - What did the responding officer do that helped the situation?
    - Was there something he/she could have done differently
    - Ask the officer – what were you thinking as you came into the situation?
    - If needed, run the role play a second time with a new officer/participant
    - Revisit relevant aspects of discussion from 1st role play

Slide 16 – Summary

- Re-state the following

- In a mental health crisis the aim is to establish safety by de-escalating the level of emotional arousal occurring, and/or avoid escalation to a higher level and eliciting basic cooperation from the person in a non-traumatic way
- In all cases the officer must practice ongoing vigilance
- Techniques centering on vigilance combined with patience, respect, active communication and a helping/caring approach are central to de-escalation
- A de-escalation approach can provide a greater level of control and safety than a command and control approach in many situations involving a mental health-related crisis

Slide 17 – Closing Thoughts

- Draw attention to slide
- Briefly discuss and encourage participants to aim for positive outcomes for citizens in a mental health crisis - They will set the stage for future interactions that are more effective and safer for all involved
- Go to Post-test